FCC

MAL.

PRACT.

THE FOLLOWING PAGES WERE TREATED AS
A UNIT IN THE ORIGINAL FILE.

Mal Practice

Summary of Medical Malpractice Insurance Bill (FCCS SCS CSHB 574)

Prepared by Representative Ted Smith

1. Authorizes Dept. of Commerce & Economic Development to provide investigative service to licensing boards.

2. Provides that for the following disciplines, upon a finding by the Director of Insurance that malpractice insurance is unavailable and the unavailability is impairing delivery of services, all licensees may be required to obtain insurance from the Medical Indemnity Corporation of Alaska. Also expands the licensing boards of these disciplines by adding two lay members, and provides additional disciplinary power to the boards:

Chiropractors
Dental Hygienists
Dentists
Nurses
Opticians
Optometrists
Pharmacists
Physical Therapists
Psychologists
Psychological Associates

3. Expands the State Medical Board of Examiners by adding lay people and deletes the requirement that members be nominated by the Alaska Medical Association. Requires each physician licensed by the state to purchase insurance from the Medical Indemnity Corporation of Alaska in the amount of $200,000 per occurance and $600,000 per year. Imposes a continuing education requirement for license renewal. Broadens disciplinary authority of the board.

4. Provides that a voluntary arbitration agreement may be entered into and, if such an agreement is in effect, sets up arbitration procedures.

5. Provides an expert advisory panel as a preliminary to court trial in any malpractice suit not covered by an arbitration agreement.

6. Revises tort law pertaining to medical malpractice as follows:

a. Changes the standard of care from that of the community to a national standard.
b. Provides for advance payments.
c. Prohibits ad damnum clause in suits.
d. Provides for periodic payments, with cost of living increases.
e. Provides that an award must be made by category of loss.
f. Provides that awards may be only for an amount exceeding awards from collateral sources unless those sources by law must seek subrogation.
g. Prohibits res ipsa loquitur.
h. Prohibits suits based on oral contracts.
i. Defines informed consent.
j. Revises "good samaritan" law to include hospital emergencies.

7. Requires hospitals as a condition of licensure to obtain insurance from the Medical Indemnity Corporation of Alaska in the amount of $200,000 per occurance, up to $1,000,000 per year, with an additional $20,000 per bed for each bed over 50. Provides for a self-insured deductible and coverage by a carrier other than the Medical Indemnity Corporation of Alaska if certain conditions are met. Requires hospitals to have a risk management program.

8. Limits liability for persons providing information to a review organization and for members of a review organization. Provides that records of a review organization are immune from discovery in a suit.

9. Establishes a medical mutual insurance corporation called Medical Indemnity Corporation of Alaska, and provides for its administration:

a. Specifies membership of its board of governors by profession.
b. Requires a plan of operation approved by the director of insurance.

c. Requires an occurance type policy and permits it to be retoractive to January 1, 1975.
d. May provide added coverage to a minimum of $ 1,000,000 for physicians and $ 5,000,000 for hospitals.
e. Requires reporting of claim information to director of insurance and licensing boards.
f. Provides that rates shall be a function of physician revenue or number of beds and may include a minimum for each category or discipline; shall consider individual risk factor disciplines and categories.
g. Permits the corporation to attempt to obtain reinsurance on the market for two years, after that time it must elect to either (1) retain all risk or (2) reinsure all risk.

10. Establishes a standby Joint Underwriting Association in the event the MICA is unable to reinsure under option (9)(g)(2) above.

11. Establishes a loan fund to loan up to $ 6,000,000 to the MICA: $ 3,000,000 for surplus and $ 3,000,000 to compensate for fluctuating loan experience. Repayment to be in annual installments at an interest rate of 4% over the discount rate.

STATE OF ALASKA
THE LEGISLATURE
LEGISLATIVE AFFAIRS AGENCY

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99801

M E M O R A N D U M

April 27, 1976

SUBJECT: Free Conference CS for Senate CS for CSHB 574

TO: Senator Jalmar Kerttula, Chairman
Senator Mike Colletta
Senator Pat Rodey
Rep. Terry Gardiner
Rep. Bob Bradley
Rep. Ted Smith

FROM: Anne Carpeneti, Legislative Counsel

The following is a list of the parts of the bill where there were minor differences between the Senate and House bills. I have tried to note them all, but probably missed some. Also noted are changes in drafting of a technical nature, dealing with the insurance provisions, which were suggested by Richard Block. I have not noted below the drafting changes made for the purpose of style and clarity only.

Page 16, lines 5 - 8
The court pays the costs of all experts called by the board and for three experts called by each side up to $150 per day for each witness

Page 17, lines 12 - 19
At the committee's suggestion the questions which may be presented to the expert advisory panel were redrafted

Page 20, lines 20 - 22
At the committee's direction, this sentence was added to clear up the periodic payments provision

Page 23, line 28
The committee accepted Mr. Block's proposal regarding waiver of insurance requirements for hospitals; Mr. Block found an error in his proposal which was corrected

Note: This change removes the power of waiver under this subsection and leaves only the power to permit a deductible

Page 24, lines 24 - 25
The provision requiring the regulations to be submitted to the Administrative Regulation Review Committee before adoption was deleted; prior review is beyond the present statutory power of the committee. The committee's power to review after adoption remains the same.

Page 30, line 1
The name of the corporation was changed to one less cumbersome

Page 30, lines 19 - 21
This is the House version which allows attorneys to be on the board of governors; attorneys may have something to contribute??

Page 33, lines 22 - 23
Provides that the corporation is exempt from membership in the Alaska Insurance Guaranty Corporation

Page 35, lines 3 - 4
The power to contract for management service is from the House version

Page 36, lines 11 - 12
The minimum rate provision is from the House bill; it is tied to the House provisions adopted by the committee on lines 7 - 10 of page 36

Page 37, lines 8 - 9 ("as developed....")
This is from the House bill

Page 37, lines 18 - 19
This is a House provision which provides for repayment of loans as a factor in rate making

Page 37, lines 27 - 28
Effective date of cancellation changed to 30 days from date of posting; the former provision (10 days from receipt) was not workable; e.g. in a case where the provider is out of state for an extended period

Page 38, line 12 (after "state.")
"except that any disability insurer may elect to pay any tax or assessment due without otherwise participating as a member." was deleted due to a constitutional defect (art. IX, sec. 7, DEDICATED FUNDS PROVISION).

Page 40, lines 23 - 24
Provides that the JUA is not a member of the Alaska Insurance Guaranty Association

Page 42, lines 15 - 21
These provisions were added in an attempt to avoid the dedicated funds problem

Page 44, lines 19-29 - page 45, lines 1-6
This excludes the corporation and JUA from participation in the Alaska Insurance Guaranty Association

The following are suggestions for changes by the Department of Commerce and Economic Development. As they are of a substantive nature, they are not included in the draft but are passed on for your consideration.

Page 15, lines 2 - 5
Mr. Block would prefer seeing the period changed to seven days with a provision excusing persons who are disabled from the seven-day limit.

Page 18, line 17 after "opinion" insert
"except that the nonappearance of a panel member for cross-examination may not for that reason alone render the report inadmissible

Page 18, lines 20 - 21
Mr. Block would limit considerably the discretion of the court to allow discovery before the report is complete

Page 38, line 24
Mr. Block would rather have the Director of Insurance appoint the board members of the JUA; his position is that this is the practice for other similar entities

Page 45, line 22
Mr. Block would have the bill apply retroactively to all cases which have arisen but have not gone to trial on the effective date of the Act

Alaska Court System

State of Alaska

303 "K" STREET
ANCHORAGE, ALASKA
99501

ARTHUR H. SNOWDEN II
ADMINISTRATIVE DIRECTOR

(907) 274-8611

March 23, 1976

Free Conference Committee on
House Bill 574
Alaska State Legislature
Pouch V
Juneau, AK 99811

Re: SCS CS HB 574 am S (Medical Malpractice)

Gentlemen:

I would like to take this opportunity to provide written comments to the Free Conference Committee on House Bill 574 to follow up on verbal discussions that my Staff Counsel had last week with Senator Rodey and Representative Gardiner concerning the payment of expert witness expenses by the Court under the Senate's proposed arbitration provisions.

Both the mandatory and voluntary arbitration provisions (Pages 11 and 13 of the Bill as amended by the Senate) require that the Court will pay the costs of experts required by the board in addition to paying compensation to each member of the arbitration board. We do not have any objections to payment of the board members' compensation, but believe there is potential for unreasonably high costs for expert witnesses under the Bill as written. We appreciate the concern that the alternative of arbitration be made as attractive as possible to litigants. We do not, however, believe that requiring the parties to bear the costs of their medical experts will substantially undermine the use of arbitration. We would, therefore, urge that the Bill provide that expert witness costs will be borne by the parties, as is the case with all other types of personal injury litigation.

Should the Committee wish to retain the provision requiring payment of experts by the Court, however, we would urge that some limitations on costs be provided in the Statute. It is not unusual for an expert medical witness from outside Alaska to charge as much as $10,000. Without any limitations on either the maximum

fee allowable or on the number of experts that may be called, a single arbitration proceeding could result in the State's having to pay very large amounts of money in expert witness costs. We would suggest that the Bill provide for a maximum fee chargeable to the Court for each expert of $150 per day, including expenses, and a limitation of no more than three experts for each party. Any excess in costs would then be paid by the party or parties.

Finally, we have attempted to develop a meaningful estimate of the costs of the arbitration process under the present provisions of the Bill, but without being able to estimate with any degree of accuracy the number, type, or local availability of expert witnesses that might be required in an arbitration proceeding, we cannot provide hard figures. However, under the limitations on costs we have suggested, and assuming each arbitration proceeding averaged five days and four experts, the cost of the expert witnesses would be approximately $3,000.

I appreciate the opportunity to provide this Committee with these comments. If you require further information, please let me know.

Very truly yours,

Arthur H. Snowden, II
Administrative Director

SB-AHS/bd

JAY S. HAMMOND
GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

April 26, 1976

Honorable Jalmar Kerttula
Chairman
Free Conference Committee
Pouch V
Juneau, Alaska 99811

Dear Senator Kerttula:

I am advised that the Free Conference Committee has made excellent progress in harmonizing the Senate and House versions of the Medical Malpractice Insurance Bill and, considering the complexities of this piece of legislation, each member of the Committee is to be commended for his dedication to this important issue.

From the outset, I have maintained that the solution to this problem required the participation of all involved segments of the medical delivery system, the health care providers, the insurers, the judicial system, the Bar and the State.

I am most disturbed, however, by the indications reaching me that your committee is seeking a solution on the insuring mechanism by requiring the State to insure the risk without any opportunity to at least try to obtain in the private market necessary reinsurance.

It was never my intention that the State be placed in the insurance business to the exclusion of the private insurance industry; only that the State provide the mechanism to make private placement more feasible. To establish a State fund which is denied statutory authority to access the private markets is placing the burden upon the State and, as such, one more step from our accepted form of government.

The compromise, I am told, includes a Joint Underwriting Association. The concept of a J.U.A. has been included in the Governor's Medical Malpractice Commission's recommendations and is basically a necessary back-up to protect the continuity of the program. I did, however, reject the concept of a J.U.A. that had no limits as to time, as to exposure, or as to coverage. The function of the J.U.A., which I understand you are now considering, is far too similar in actual economic effect to that which I vetoed last year.

I trust that the legislature will not permit an otherwise exemplary piece of meaningful legislation that they have created to be jeopardized by including an insuring mechanism which causes this Administration much concern.

It would be my pleasure to have you, as Chairman of the Free Conference Committee, call upon me to discuss my concerns and to jointly consider a mutually acceptable solution.

Sincerely,

Jay S. Hammond
Governor

STATE OF ALASKA
THE LEGISLATURE

POUCH Y · STATE CAPITOL
JUNEAU, ALASKA 99801

LEGISLATIVE AFFAIRS AGENCY

MEDICAL MALPRACTICE BILLS IN FREE CONFERENCE COMMITTEE

House Version	Senate Version
Requires the Division of Occupational Licensing to provide investigative services to licensing boards of health care providers	Same provision in Senate bill
Requires chiropractors and dentists to carry medical malpractice insurance of at least $200,000/600,000 coverage; requires dental hygienists, nurses, dispensing opticians, optometrists, pharmacists, physical therapists, psychologists and psycholigical associates to carry medical malpractice insurance of at least $100,000/300,000 coverage; provides that these health care providers shall be required to purchase their insurance from the Alaska Health Care Providers Indemnity Corporation if, after a hearing, the director of insurance finds that the insurance is not available on the voluntary market and the unavailability is impairing delivery of their services	No similar provision in Senate bill
Requires physicians to purchase medical malpractice insurance from the Alaska Health Care Providers Indemnity Corporation (corporation) in amounts of at least $200,000/600,000 coverage	Same provision in Senate bill
No similar provision in House bill	Adds two public members to the licensing boards of all health care providers and staggers the terms of the public members

April 28, 1976

SUGGESTIONS AND CORRECTIONS - FCCS SCSCS HB574

p. 5 l. 9-11 Restore nominations by ASMA

Reason: The governor will need all the help he can get to find physicians who will be willing to serve on a board with vast new and often unpleasant duties. Purely political appointments by governors in the past have often not worked out well.

p. 15 l. 8 Add "," after "hospital"; strike "or"; after "clinic, add "or practitioner" so that the line reads " hospital, clinic, or practitioner."

Reason: No reason to exclude a physician not in a clinic or H.M.O.

p.16 l. 27,28 Delete "unless the court decides" and substitute "unless all parties
p.45 l. 19,20 agree"

Reason: The court has made it very clear that it is opposed to expert advisory panels. It should not have the opportunity to bypass the expert advisory panel.

p.17 l. 10,11 Strike "in the court's discretion"

Reason: Same as above.

p.17 l. 12-19 Add two new questions and re-number:
After question (1), add new question: What would have been the outcome without medical care? After question (4), add new question: What specifically caused the injury?

Reason: Question (2) describes the seriousness of the situation and is a very important part of "telling the medical story". Question (4) gets to the heart of the case and should obviously not be avoided.

p. 27 between lines 4 & 5. Reinsert quidelines section of SB 113 passed by Senate last year.

"Sec. 18.23.040 Quidelines not admissible in evidence. No guideline established by a review organization is admissible in evidence in a proceeding brought by or against a professional by a person to whom the professional has rendered professional services."

Reason: A review committee guideline standard should not be commandeered to "hang" a plaintiff.

p. 32 l. 18 & l. 20 Strike "who are physicians"

Reason: any employees of a physician or hospital should be insurable under the physician's or hospital's policy. This is current practice. For example, my office secretary and nurse were insured under my policy -- when I had one.

p. 32 l. 28 After hospital add "for any period"

Reason: Make it clear that one doesn't have to reinsure the entire period back to December 31, 1974. He may have just had 1 or 2 short gaps in coverage.

STATE OF ALASKA
THE LEGISLATURE
LEGISLATIVE AFFAIRS AGENCY

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99801

MEDICAL MALPRACTICE BILLS IN FREE CONFERENCE COMMITTEE

House Version	Senate Version
35. Page 2, line 2: demonstrated lack of competence, experience, or education	Page 2, line 5: demonstrated problems of competence, experience, education or health
36. Page 4, line 4: The director of insurance or his designee may waive	Page 4, line 23: The director of insurance or his designee shall waive
37. Page 13, lines 23-29 Page 14, lines 1-3 Mechanical and drafting differences in House and Senate bills	Page 16, lines 15-24
38.	Page 8, after line 29: AS 08.80.070 needs to be amended to change quorum requirements

33 Creates a revolving loan fund in the Department of Commerce and Economic Development to loan funds to the corporation when necessary for the corporation to maintain adequate reserves; loans shall be repaid by the corporation within four years at an annual interest rate of 7%; the director of insurance may sell notes of the corporation to the Department of Revenue	Creates a revolving loan fund in the Department of Economic Development to loan funds to the JUA when necessary to spread costs over time because of fluctuations in loss experience; loans shall be repaid by the JUA within five years at an annual interest rate of 6%; the director may sell notes of the JUA to the Department of Revenue
34 No similar provision in House bill	Provides for limited immunity from defamation for members of licensing boards of health care providers

Adopt Senate version 21.88.080 A(2)

29, line 15

25 Requires the corporation to insure all those health care providers about which a finding has been made that insurance is not available on the private market	~~Provides~~ that the corporation may insure health care providers other than physicians and hospitals on an individual basis
House version 26 Allows the corporation to provide risk management advice and services to hospitals	No similar provision in Senate bill
Senate 27 No similar provision in House bill	Assesses a premium tax on the corporation
House version 28 Requires that rates for physicians be set as a function of medical revenues, and rates for hospitals be set as a function of the number of beds in the hospital	No similar provision in Senate bill
Senate version 29 No similar provision in House bill	Provides that rates may not be unfairly discriminatory
30 House Version Requires that disciplines and classifications within license categories be considered in rate making	This is not addressed specifically although the Senate version does require that individual risk factors be considered
30(A) - Adopt Senate 31 Requires that repayment of loan obligations be considered in rate making	Take a look at (B) Block + ANNE No similar provision in Senate bill
32 No similar provision in House bill	Creates a JUA to provide reinsurance to the corporation for that portion of the risk that the corporation is unable to reinsure on the private market

17 Expands good samaritan rule	Same provision in Senate bill
18 Requires hospitals to purchase medical malpractice insurance from the corporation for $200,000 per occurrence and an aggregate coverage of $1,000,000 plus $20,000 for each bed over 50	Same provision in Senate bill
19 Requires hospitals to have internal risk management programs	The same provision passed the Senate in a separate bill
20 Provides limited immunity from defamation claims for members of health care review organizations and persons testifying before health care review organizations	Same provisions in Senate bill
21 Creates the Alaska Health Care Providers Indemnity Corporation	Senate bill creates similar corporation
22 Board members are appointed by the director of insurance; the physician and hospital representatives are appointed from lists submitted by their professional organizations	Board members are appointed by the governor and confirmed by the legislature, with no requirement that they be appointed from lists submitted by professional organizations
23 Board members receive $100 per day while meeting and reasonable travel expenses	Board members set their own compensation
24 No similar provision in House bill	Requires corporation to obtain reinsurance from the private market if possible

Expands the standard of care required of health care providers to that of other providers in the same field or specialty	Same provision in Senate bill
No similar provision in House bill	Provides that advance payment by a health care provider or its insurer is not an admission of liability
No similar provision in House bill	Prohibits use of an ad damnum clause in medical malpractice cases
Allows damages to be paid on a periodic or lump sum basis; provides that awards paid periodically be increased according to annual increases in the consumer price index	The Senate bill has a similar provision regarding lump sum or periodic payment but does not provide for increases according to inflation for periodic payments
Provides that awards in malpractice cases be decreased by collateral sources received by plaintiff	The Senate bill has a similar provision, but allows an amount to be added back to the award or set aside where tnere is a second injury and insurance benefits are exhausted
Redrafts provision dealing with jury instructions in malpractice cases	Same provision in Senate bill
Provides that no action may arise against a provider for breach of an oral contract to provide a specific cure or result	No similar provision in Senate bill
Provides the circumstances where an action can be brought for failure to obtain informed consent of patient, and also sets out the defenses to a claim based on failure to obtain informed consent	Same provision in Senate bill

5 No similar provision in House bill	Deletes the requirement that members of the licensing boards of health care providers be appointed by the governor from a list supplied by the professional society
6 Expands the disciplinary powers of the licensing boards of health care providers	Same provision in Senate bill
7 Requires physicians to meet continuing education standards set by the State Medical Board	No similar provision in Senate bill
8 Requires that all medical malpractice claims be submitted to an expert advisory panel to be appointed by the court; expenses of the panel shall be borne by the state, except where a party has made a patently frivolous claim or denial of liability in which case that party shall pay the expenses	Provides three options to encourage fast and fair settlement of malpractice cases: Mandatory arbitration of claims against physicians and hospitals unless all parties agree to waive arbitration; the decision of the arbitration board may be appealed to the superior court for a trial de novo unless the parties agreed to binding arbitration; findings of the arbitration board are admissible at the trial de novo if the court finds the arbitration was conducted fina the arbitration was conducted properly; Voluntary arbitration of malpractice claims against any health care provider; As an alternative to arbitration, the case shall be submitted to an expert advisory panel, unless the court determines an expert advisory panel to be unnecessary for a decision in the case; The court bears the costs of the arbitration or the expert advisory panel, except whe e a party has made a patently frivolous claim or denial of liability, in which case that party pays the expenses of either the arbitration or the expert advisory panel

good bargaining stock

The attached bar charts demonstrate the various kinds of reinsurance and a few of the combinations of them used. Many other combinations are possible. For example, facultative reinsurance can be purchased on an excess basis, stop loss aggregate basis, quota share basis, or total treaty. The percentages and limits are variable items. Retentions by the primary insurer are variable.

The charts demonstrate the following types and kinds of reinsurance:

1. No reinsurance
2. 100% treaty quota share
3. Excess of $50,000.
4. Stop loss aggregate $500,000.
5. Excess of $50,000. and stop loss aggregate $400,000.
6. 80% quota share
7. 80% quota share with $500,000. stop loss aggregate
8. 100% facultative on risk generating losses 3, 5 & 10
9. M.I.C.A. example

Shaded areas on charts 2 - 9 indicate portion of loss reinsured.

What happens to JUA under proposal on 3 year division

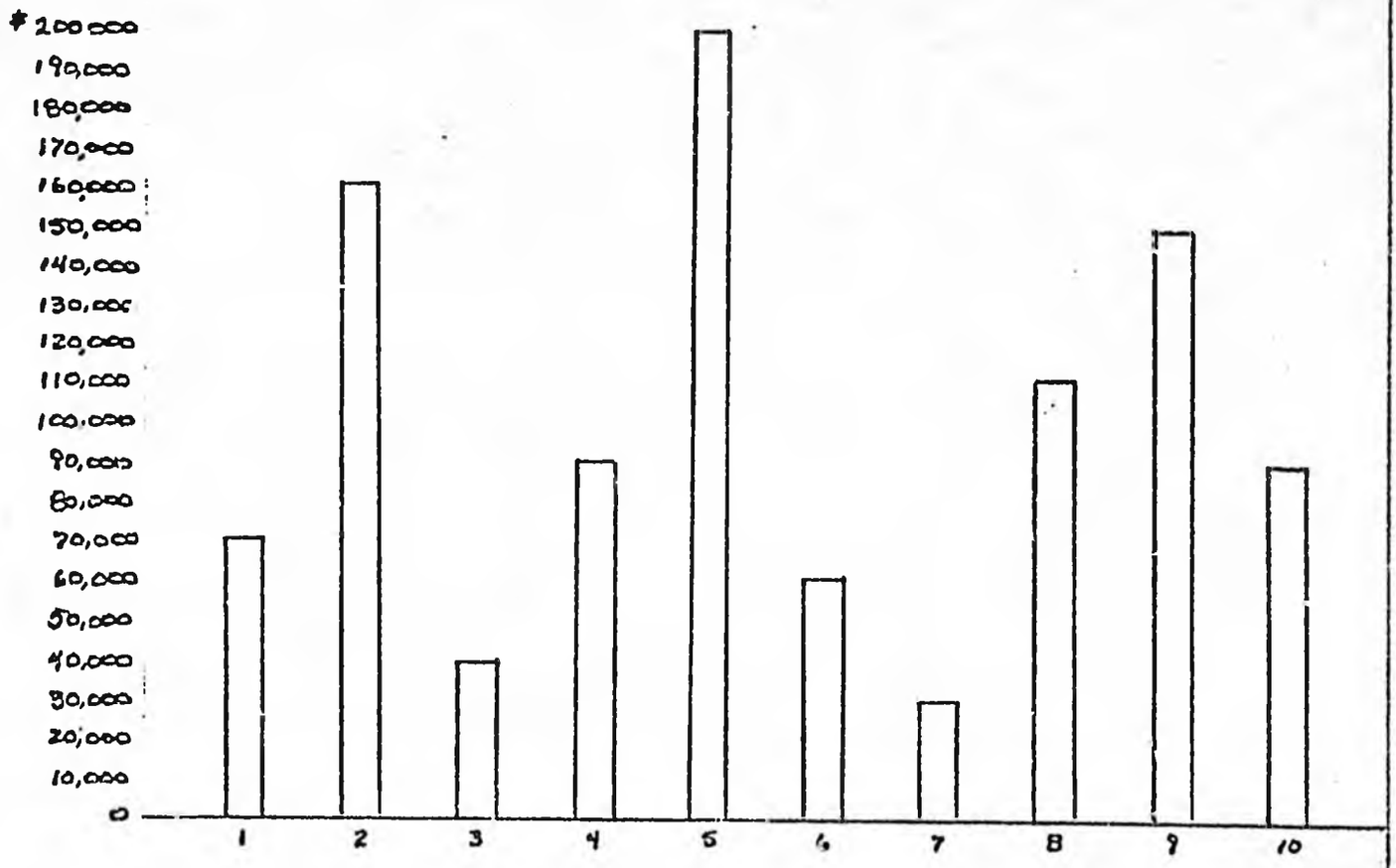
change rate of interest

THE BAR CHART BELOW REPRESENTS TEN (10) INSURANCE LOSSES WITH ONE INSURANCE COMPANY WHICH, IN THE AGGREGATE, TOTAL $1,000,000.

TYPE OF REINSURANCE: NONE

LOSS RETAINED BY INSURANCE COMPANY: $1,000,000.

LOSS ASSUMED BY REINSURANCE: $ 0.

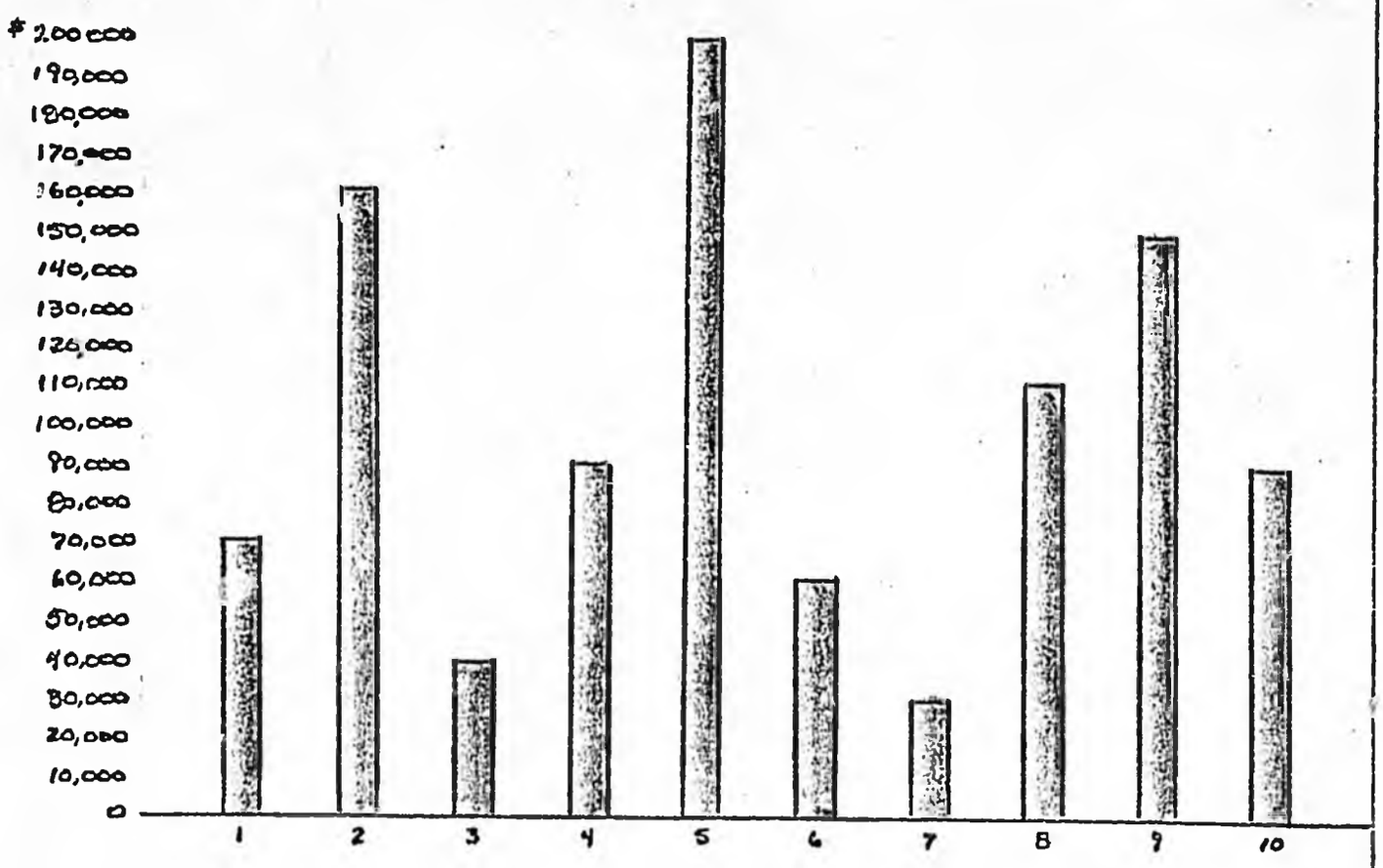


THE BAR CHART BELOW REPRESENTS TEN (10) INSURANCE LOSSES WITH ONE INSURANCE COMPANY WHICH, IN THE AGGREGATE, TOTAL $1,000,000.

TYPE OF REINSURANCE: 100% TREATY QUOTA SHARE

LOSS RETAINED BY INSURANCE COMPANY: $0

LOSS ASSUMED BY REINSURANCE: $1,000,000

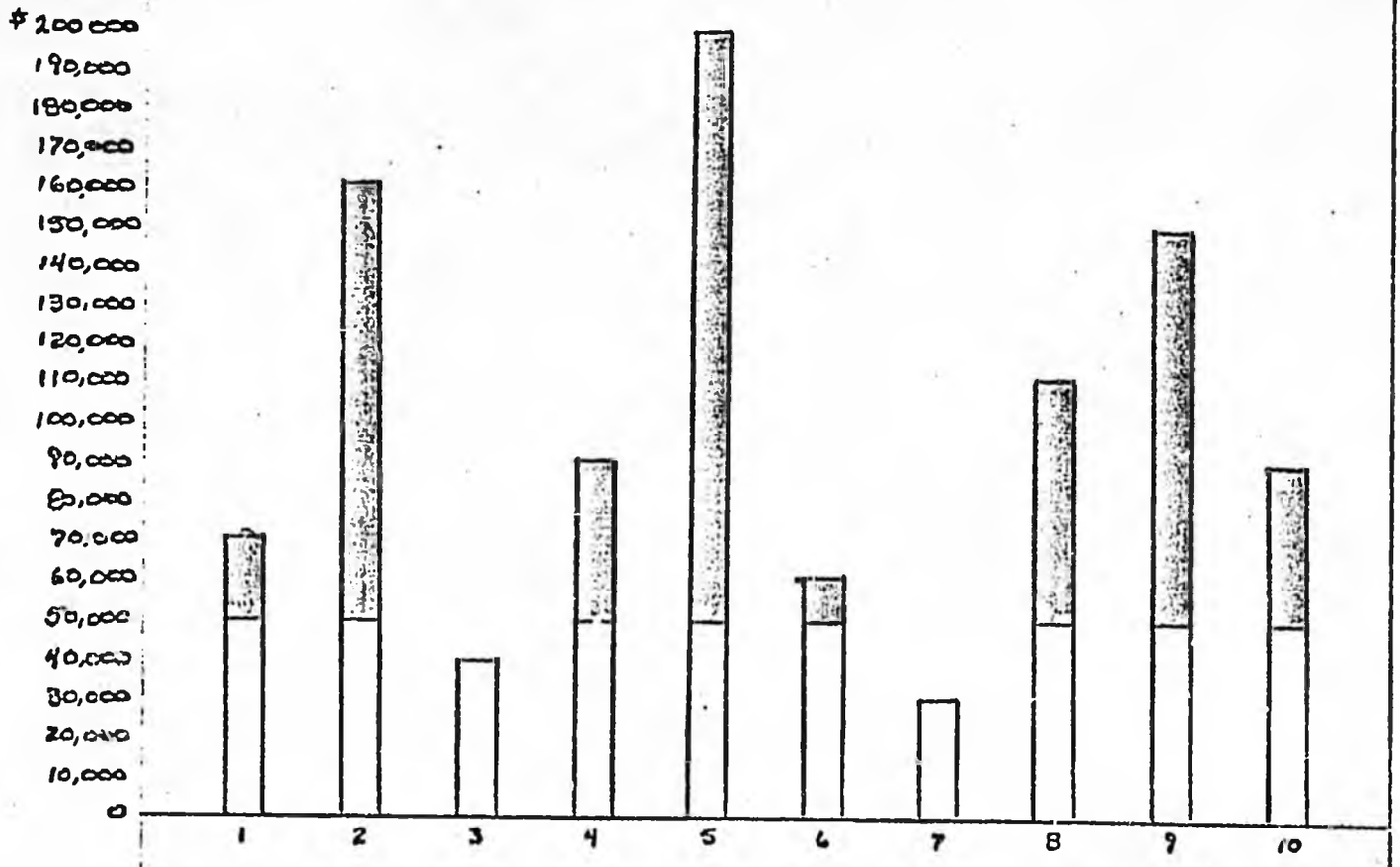


THE BAR CHART BELOW REPRESENTS TEN (10) INSURANCE LOSSES WITH ONE INSURANCE COMPANY WHICH, IN THE AGGREGATE, TOTAL $1,000,000.

TYPE OF REINSURANCE: EXCESS OF $50,000

LOSS RETAINED BY INSURANCE COMPANY: $470,000.

LOSS ASSUMED BY REINSURANCE: $530,000

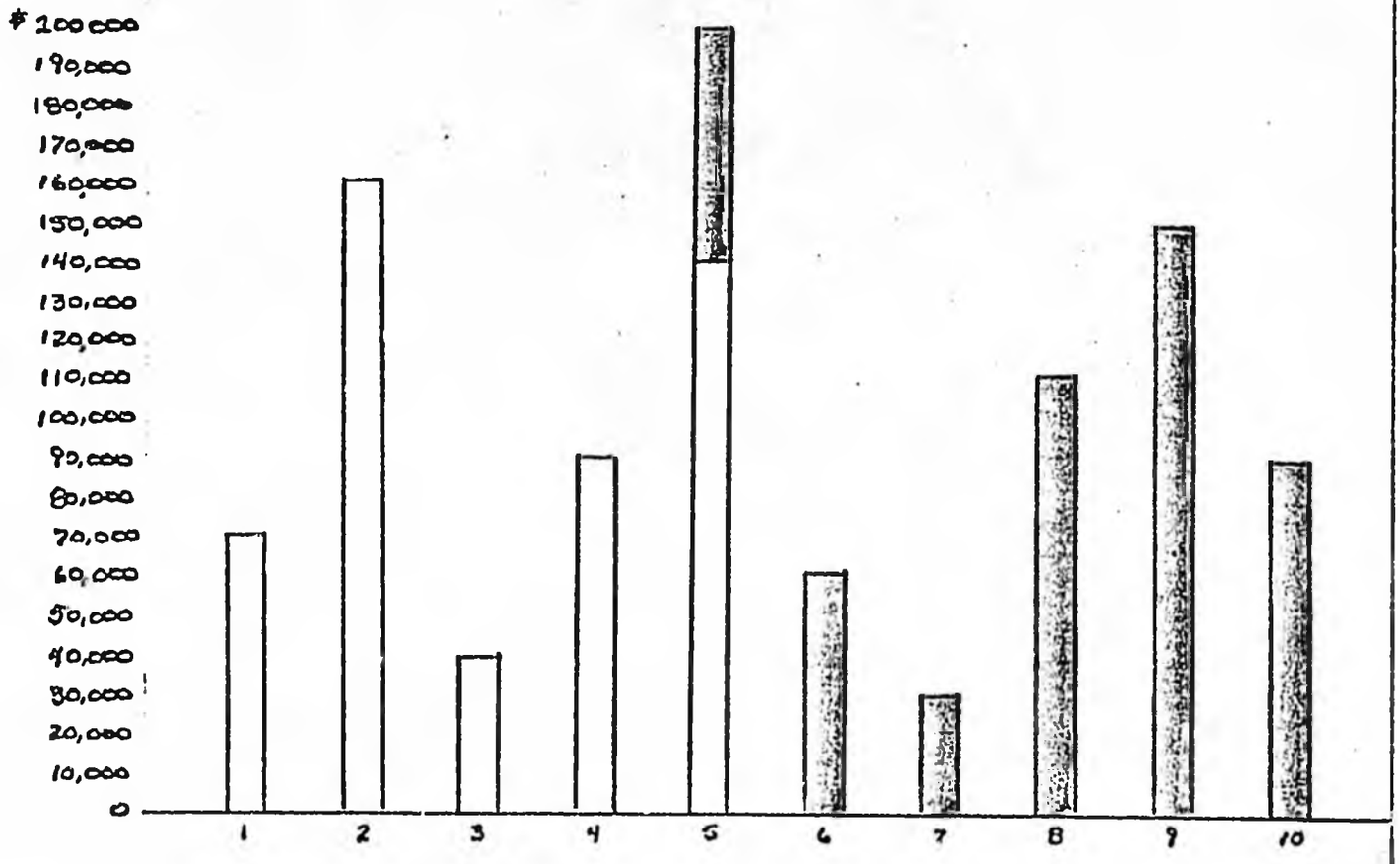


THE BAR CHART BELOW REPRESENTS TEN (10) INSURANCE LOSSES WITH ONE INSURANCE COMPANY WHICH, IN THE AGGREGATE, TOTAL $1,000,000.

TYPE OF REINSURANCE: STOP LOSS AGGREGATE $500,000.

LOSS RETAINED BY INSURANCE COMPANY: $500,000.

LOSS ASSUMED BY REINSURANCE: $500,000.

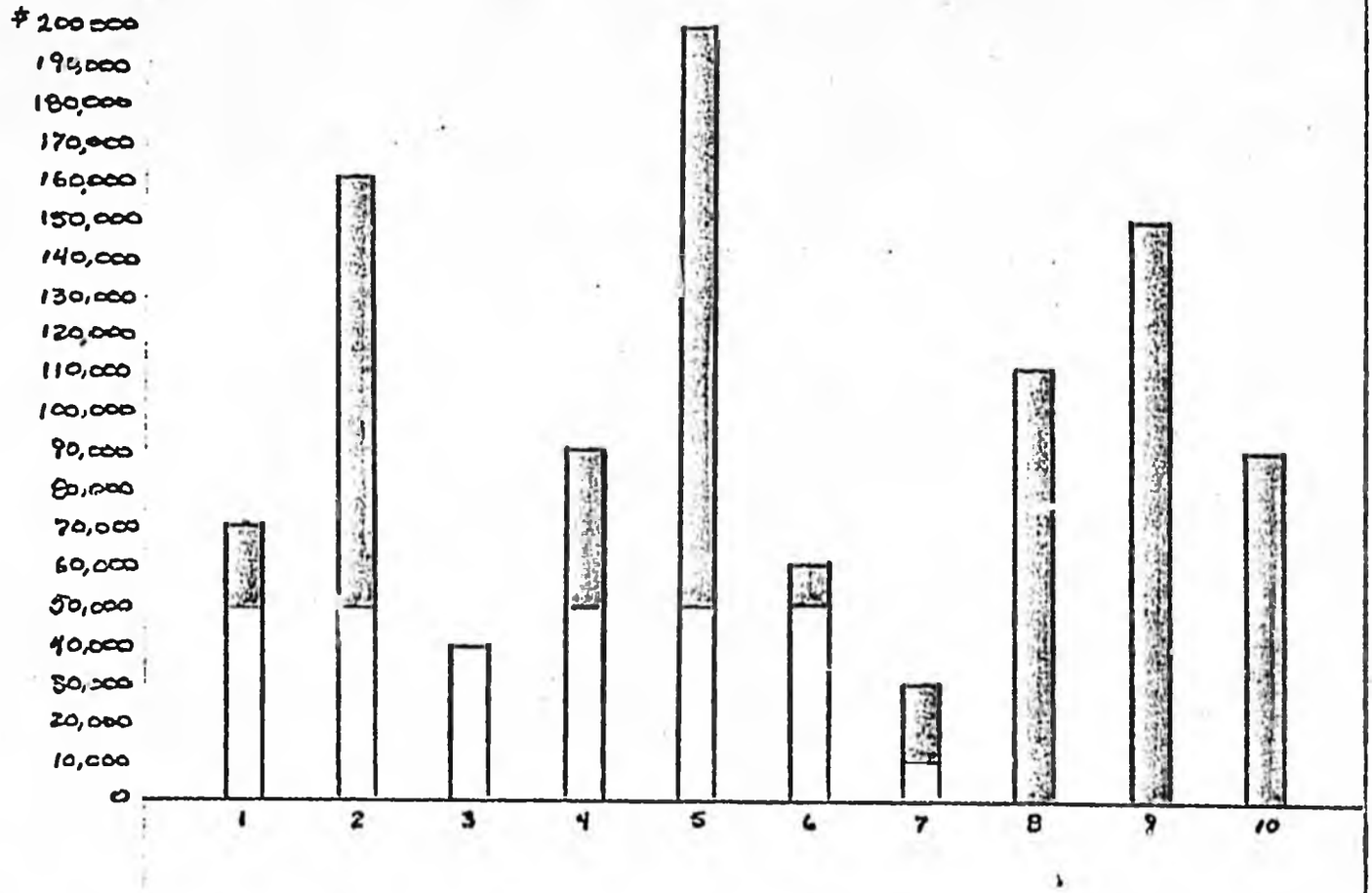


THE BAR CHART BELOW REPRESENTS TEN (10) INSURANCE LOSSES WITH ONE INSURANCE COMPANY WHICH, IN THE AGGREGATE, TOTAL $1,000,000.

TYPE OF REINSURANCE: EXCESS OF $50,000 AND STOP LOSS AGGREGATE $300,000.

LOSS RETAINED BY INSURANCE COMPANY: $300,000.

LOSS ASSUMED BY REINSURANCE: $700,000.

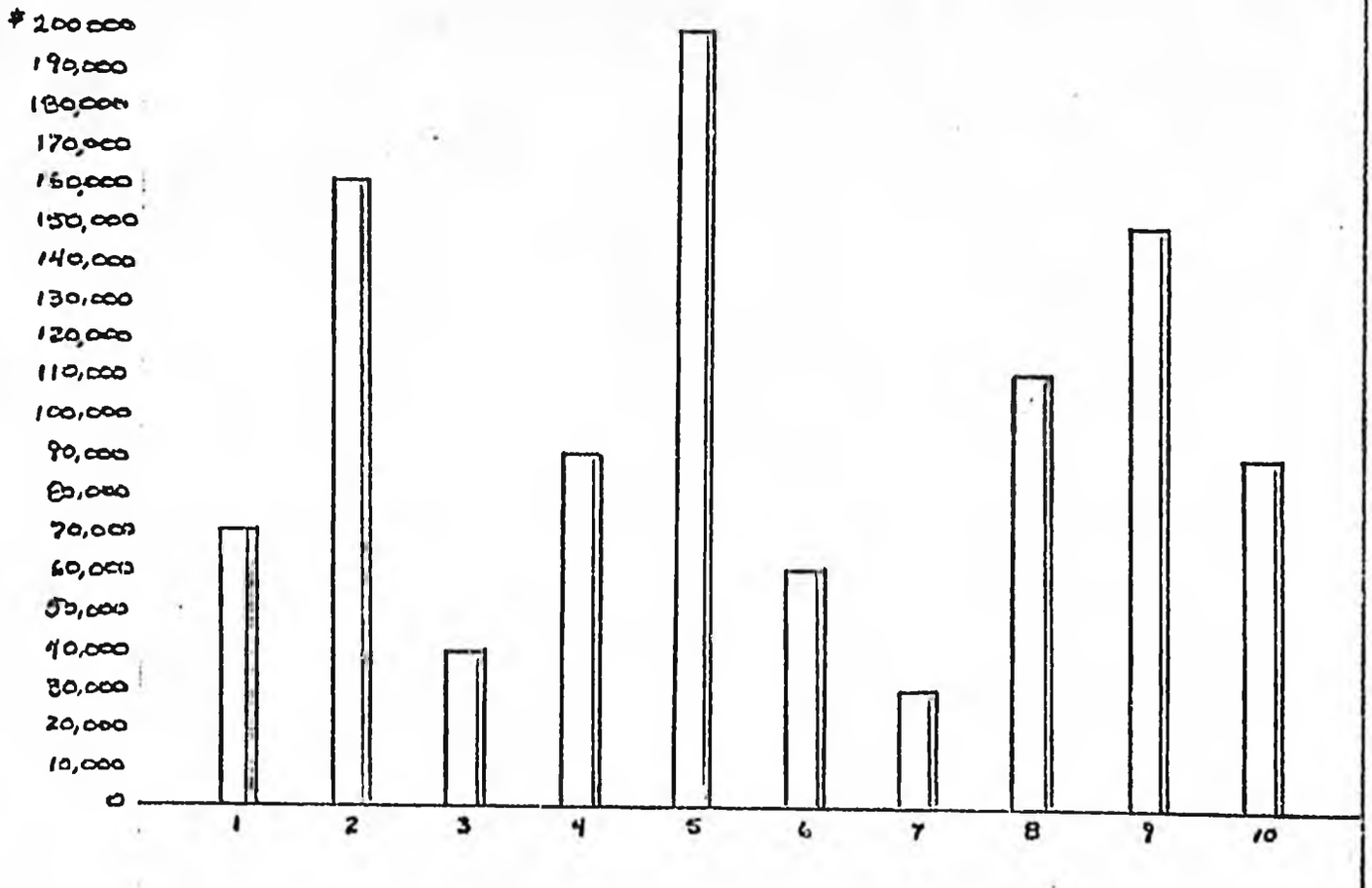


THE BAR CHART BELOW REPRESENTS TEN (10) INSURANCE LOSSES WITH ONE INSURANCE COMPANY WHICH, IN THE AGGREGATE, TOTAL $1,000,000.

TYPE OF REINSURANCE: 80% QUOTA SHARE

LOSS RETAINED BY INSURANCE COMPANY: $800,000

LOSS ASSUMED BY REINSURANCE: $200,000

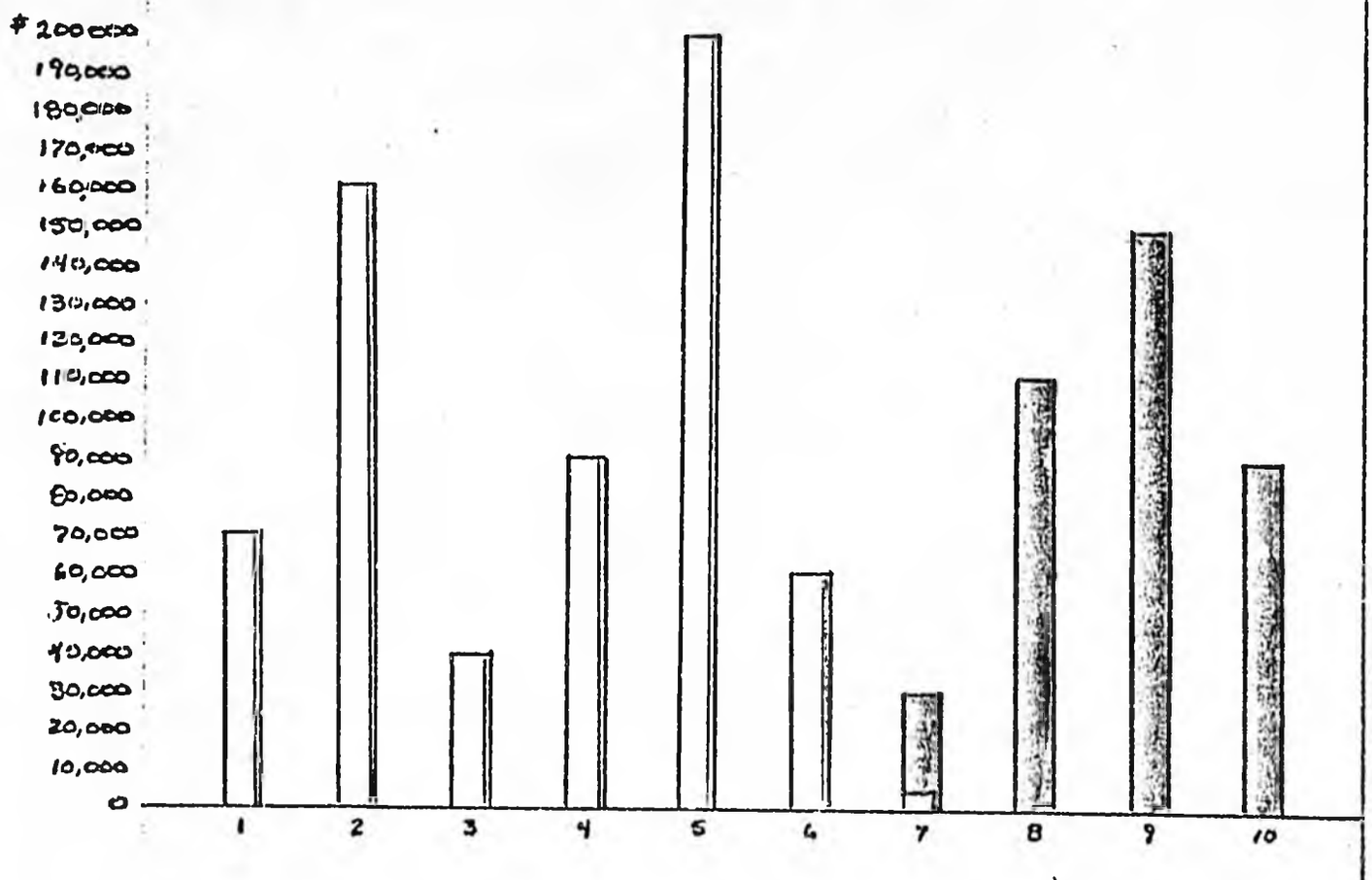


THE BAR CHART BELOW REPRESENTS TEN (10) INSURANCE LOSSES WITH ONE INSURANCE COMPANY WHICH, IN THE AGGREGATE, TOTAL $1,000,000.

TYPE OF REINSURANCE: 80% QUOTA SHARE WITH $500,000 STOP LOSS AGGREGATE

LOSS RETAINED BY INSURANCE COMPANY: $500,000

LOSS ASSUMED BY REINSURANCE: $500,000

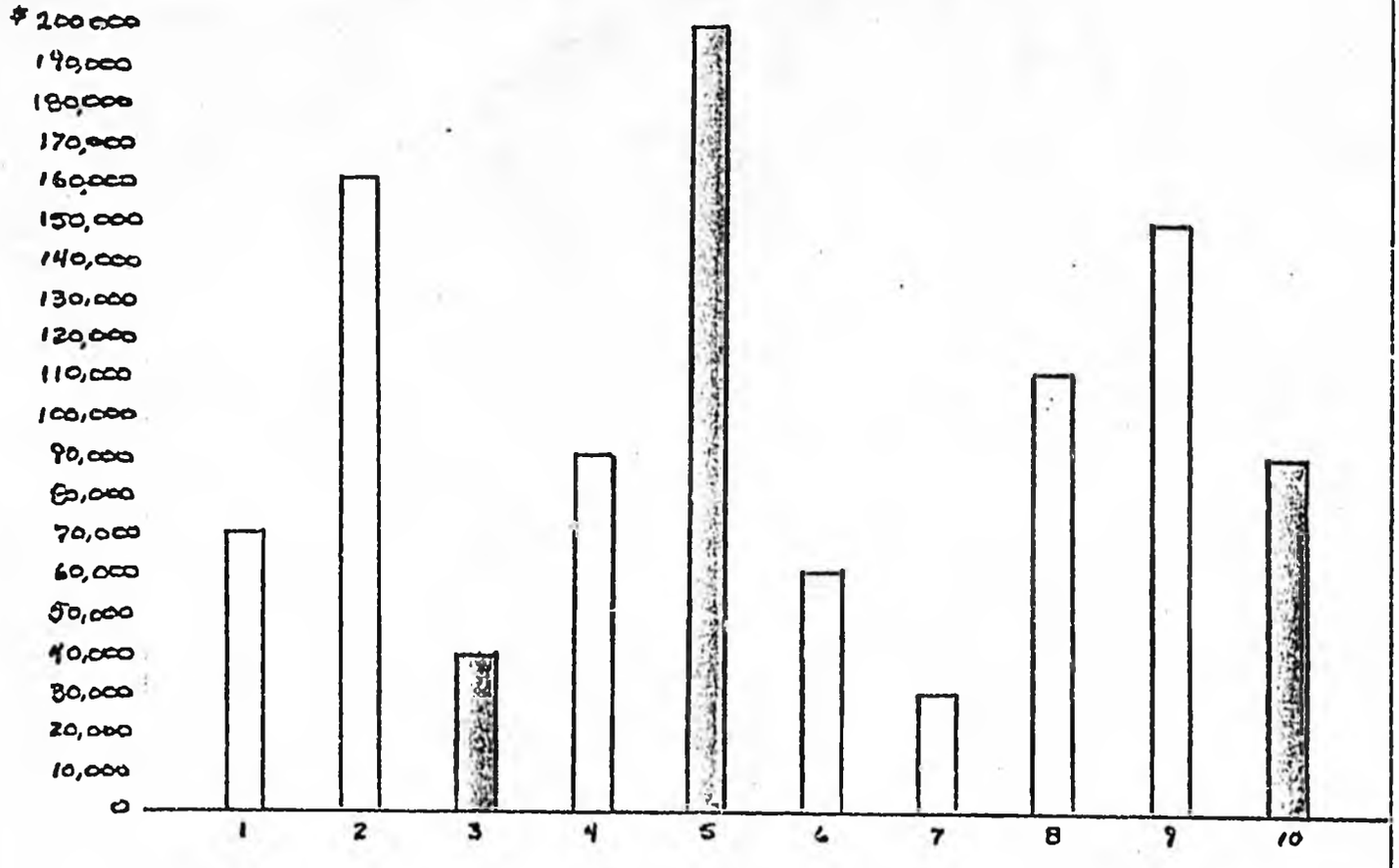


THE BAR CHART BELOW REPRESENTS TEN (10) INSURANCE LOSSES WITH ONE INSURANCE COMPANY WHICH, IN THE AGGREGATE, TOTAL $1,000,000.

TYPE OF REINSURANCE: 100% FACULTATIVE ON RISK GENERATING LOSSES 3,5+10.

LOSS RETAINED BY INSURANCE COMPANY: $670,000.

LOSS ASSUMED BY REINSURANCE: $330,000.

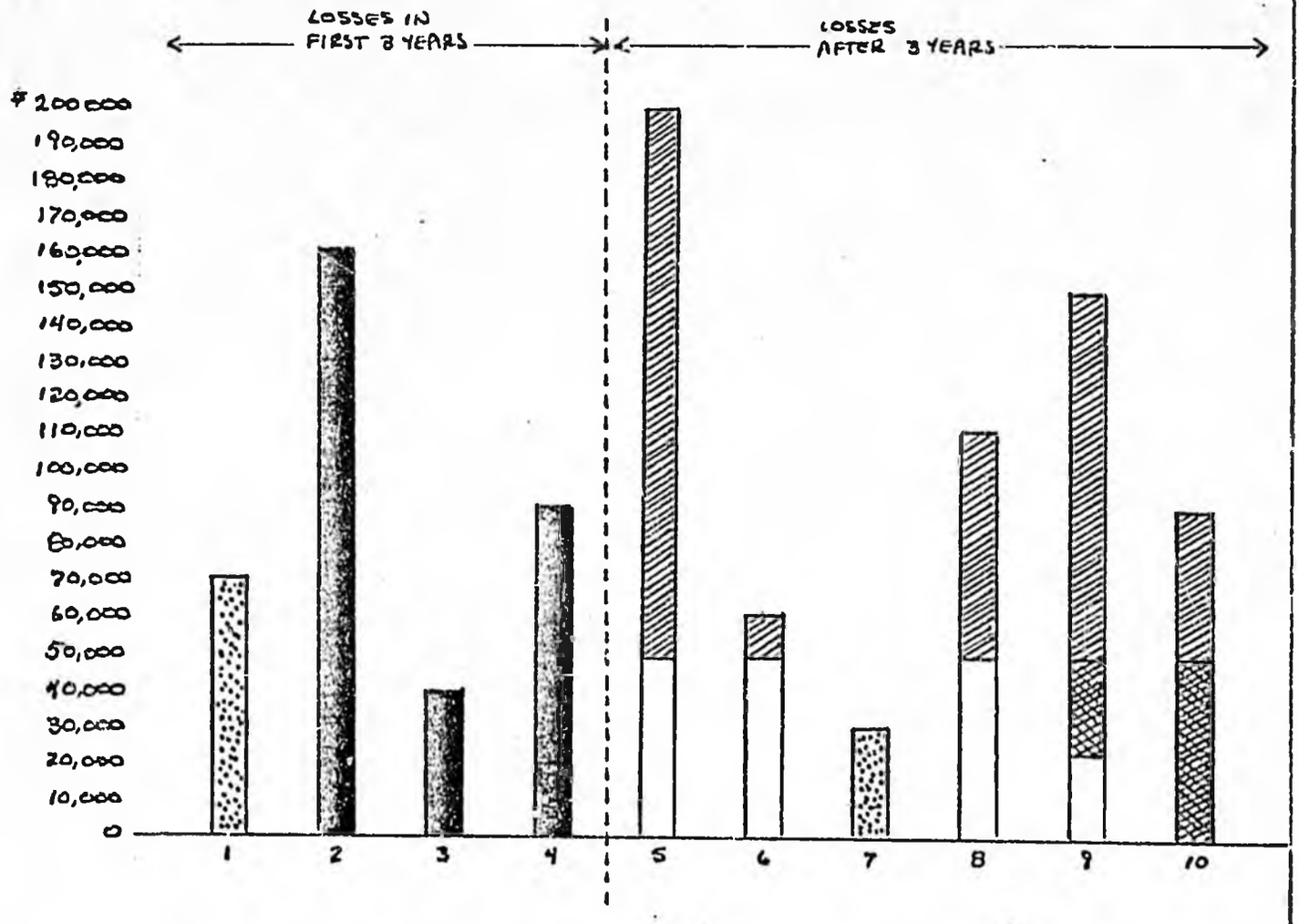


THE BAR CHART BELOW REPRESENTS TEN (10) INSURANCE LOSSES WITH THE M.I.C.A. WHICH, IN THE AGGREGATE, TOTAL $1,000,000.

TYPE OF REINSURANCE: VARIOUS · SEE BELOW

LOSS RETAINED BY M.I.C.A.: $175,000.

LOSS ASSUMED BY REINSURANCE: $825,000.



LOSS RETAINED BY MIC

HOSPITAL FACULTATIVE

100 % QUOTA SHARE (TOTALLY REINSURED)

EXCESS OF $50 000 ON LOSSES BROUGHT AFTER 3 YEARS

STOP LOSS AGGREGATE $175,000 ON LOSSES BROUGHT AFTER 3 YEARS

AMENDMENT

page 17, lines 12 - 20 substitute following language

(1) What was the disorder for which the plaintiff came to medical care?

(2) What would have been the outcome without medical care?

(3) Was the treatment selected appropriate for the case?

(4) Did an injury arise from the medical care?

(5) What is the nature and extent of the injury?

(6) What specifically caused the injury?

(7) Was the injury caused by unskilful care?

(8) If an injury had not occurred, how would the plaintiff's condition differ from his present condition?

Amendment To Free Conference CS For Senate CS For CS For House Bill 574

Page 23, line 29
Subsection (c)

...the policy for a hospital if the hospital demonstrates to the satisfaction of the director of insurance that without indemnity from any other source the hospital has the financial resources to discharge the maximum potential exposure to the hospital by reason of the deductible provision and the conditions of subsection (e) are satisfied.

Page 24, line 4

following subsection (c) insert subsections (d) and (e) with the following language:

(d) The Director of Insurance shall permit a hospital to insure directly all or any portion of its risk with a carrier, authorized to sell Malpractice Liability Insurance in this state if the Director of Insurance finds that permitting direct insurance will not jeopardize the insuring program of the Medical Indemnity Corporation of Alaska and the conditions of subsection (e) are satisfied.

(e) To qualify for authority to use a deductible provision the hospital, in addition to the requirements of subsection (c), or to insurer directly in addition to the requirements of subsection (b), the hospital and insurer, must:

(1) agree to permit the Medical Indemnity Corporation of Alaska to provide the defense to any claim brought against the hospital if any health care provider insured by the corporation is also, or may become, involved in the claim and to reimburse the corporation for a pro rata portion of the costs of defense; and

(2) agree to waive any right of cross complaint, counter claim or subrogation against a health care provider insured by the Medical Indemnity Corporation of Alaska, except that such agreement may provide for arbitration among involved health care providers to determine allocation of liability.

line 10, (c) (3) is changed to (e) (3).

THE PRECEDING PAGES WERE TREATED AS
A UNIT IN THE ORIGINAL FILE.

Jud. 23

Original sponsor: Rules Committee by request of the Governor

IN THE HOUSE BY THE JUDICIARY COMMITTEE

CS FOR HOUSE BILL NO. 574

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to liability for the provision of health care services; changing the Alaska Supreme Court's Rules of Civil Procedure; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 08.01.050 is amended by adding a new paragraph to read:

(19) provide investigative services to the boards established under chs. 20, 32, 36, 64, 68, 71, 72, 80, 84, and 86 of this title, for the purpose of assisting those boards in matters of professional discipline.

* Sec. 2. AS 08.20 is amended by adding new sections to read:

Sec. 08.20.115. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance against liability to patients for chiropractic malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require all persons licensed under this chapter to obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for chiropractors is impairing the delivery of chiropractic services to the public.

Sec. 08.20.175. LIMITS OR CONDITIONS ON LICENSE; REPRIMAND. (a)

In addition to action under sec. 170 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice chiropractic should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 3. AS 08.32 is amended by adding new sections to read:

Sec. 08.32.015. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $100,000 per occurrence and $300,000 aggregate liability per year. This requirement is satisfied if the person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require all persons licensed under this chapter to obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for dental hygienists is impairing the delivery of dental hygienists' services to the public.

Sec. 08.32.165. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 160 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice dental hygiene should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any

action taken by the board under this section.

* Sec. 4. AS 08.36 is amended by adding new sections to read:

Sec. 08.36.115. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance against liability to patients for dental malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require all persons licensed under this chapter to obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for dentists is impairing the delivery of dentist services to the public.

Sec. 08.36.325. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 320 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice dentistry should be limited or conditioned or the practitioner disciplined, the board may censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining. require counseling

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 5. AS 08.64 is amended by adding new sections to read:

Sec. 08.64.215. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance issued by the Health Care Providers Indemnity Corporation against liability to patients for medical malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This

requirement is satisfied if a person's employer maintains insurance for him from the Health Care Providers Indemnity Corporation in the required amounts.

(b) The director of insurance or his designee may waive the requirement in (a) of this section for a person if that person furnishes satisfactory evidence of his having other insurance providing coverage in amounts not less than those specified in (a) of this section. No waiver granted under this subsection may extend beyond the normal expiration date of the person's insurance policy or January 1, 1977, whichever occurs first.

Sec. 08.64.312. CONTINUING EDUCATION REQUIREMENTS. (a) The board shall promote a high degree of competence in the practice of medicine by requiring every physician licensed in the state to fulfill continuing education requirements.

(b) Before a license may be renewed the licensee shall submit evidence to the board that continuing education requirements prescribed by regulations adopted by the board have been met.

(c) The board may exempt a physician from the requirements of (b) of this section upon an application by him giving evidence satisfactory to the board that he is unable to comply with the requirements because of extenuating circumstances. However, no person may be exempted from more than 15 hours of continuing education in a five-year period.

Sec. 08.64.325. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 330 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 6. AS 08.68 is amended by adding new sections to read:

Sec. 08.68.165. INSURANCE REQUIRED. (a) To be eligible for an active license as a nurse under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $100,000 per occurrence and $300,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require all persons licensed under this chapter to obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for nurses is impairing the delivery of nurse services to the public.

Sec. 08.68.275. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 270 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice nursing should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section

* Sec. 7. AS 08.71 is amended by adding new sections to read:

Sec. 08.71.085. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $100,000 per occurrence and $300,000 aggregate liability per year. This

requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require that all persons licensed under this chapter obtain the insurance required under (a) of this section if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for dispensing opticians is impairing delivery of the services of dispensing opticians to the public.

Sec. 08.71.175. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 170 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice as a dispensing optician under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by procedure or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 8. AS 08.72 is amended by adding new sections to read:

Sec. 08.72.115. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $100,000 per occurrence and $300,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require all persons licensed under this chapter to obtain insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for optometrists is impairing delivery of optome-

trist services to the public.

Sec. 08.72.255. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under secs. 240 and 250 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice optometry under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 9. AS 80.80 is amended by adding new sections to read:

Sec. 08.80.135. INSURANCE REQUIRED. (a) To be eligible for active registration as a pharmacist, a person must maintain insurance against liability to patients for malpractice in limits of not less than $100,000 per occurrence and $300,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require that all persons licensed under this chapter obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for pharmacists is impairing delivery of pharmacist services to the public.

Sec. 08.80.265. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 260 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice pharmacy under this chapter should be limited or conditioned or the practitioner disciplined, the board may

reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 10. AS 08.84 is amended by adding new sections to read:

Sec. 08.84.035. INSURANCE REQUIRED. (a) To be eligible for active registration as a physical therapist under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $100,000 per occurrence and $300,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require that all persons licensed under this chapter obtain the insurance required in (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for physicial therapists is impairing delivery of physical therapist services to the public.

Sec. 08.84.185. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 180 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice physical therapy should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 11. AS 08.86.120 is amended to read:

Sec. 08.86.120. ENTITLEMENT TO LICENSURE. A person who passes the examination given by the board <u>and possesses the insurance required by</u>

sec. 125 of this chapter is entitled to be licensed as a psychologist.

* Sec. 12. AS 08.86.160 is amended to read:

Sec. 08.86.160. ASSOCIATES: ENTITLEMENT TO LICENSURE. A person who passes the examination given by the board and who possesses insurance in accordance with sec. 125 of this chapter is entitled to be licensed as a psychological associate.

* Sec. 13. AS 08.86 is amended by adding new sections to read:

Sec. 08.86.125. INSURANCE REQUIRED. (a) To be eligible for active licensure as a psychologist under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $100,000 per occurrence and $300,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require all persons licensed under this chapter to obtain insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for psychologists is impairing the delivery of psychologist services to the public.

Sec. 08.86.220. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) Upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice psychology or as a psychological associate under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure place on probation, restrict practice by time, specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 14. AS 09.55.530 is repealed and re-enacted to read:

ARTICLE 6. MALPRACTICE ACTIONS.

Sec. 09.55.530. DECLARATION OF PURPOSE. The legislature finds that the health of the people is threatened by curtailment of health care services due to the difficulty in obtaining adequate malpractice insurance at a reasonable cost. It is the purpose of secs. 530 - 560 of this chapter to protect the health and safety of the people of this state by establishing procedural aids for handling malpractice claims which will help ensure the ready availability of adequate insurance at a reasonable cost and which will be fair to all parties concerned.

* Sec. 15. AS 09.55 is amended by adding a new section to read:

Sec. 09.55.536. EXPERT ADVISORY PANEL. (a) In any action for damages due to personal injury or death based upon the provision of professional services by a health care provider, the court shall establish a three-person expert advisory panel in accordance with this section. When the action is filed the court shall, by order, determine the professions or specialties to be represented on the expert advisory panel and shall advise each party of the professions or specialties to be represented, giving the parties the opportunity to object or make suggestions. The court may in its discretion conduct other preliminary proceedings relative to the composition of the panel as it considers appropriate.

(b) The expert advisory panel may compel the attendance of witnesses, interview the parties and physically examine the injured person if alive, consult with the specialists or learned works they consider appropriate, and compel the production of and examine all relevant hospital, medical, or other records or materials relating to the health care treatment. The panel may meet in camera, but shall maintain a record of any testimony or oral statements of witnesses, and shall keep copies of all written statements and opinions it receives. Not less

Not More than 30?

than 30 days after selection of the panel, it shall make a written report to the parties and to the court, substantially answering the following questions in addition to any other question which the court puts to the panel:

(1) Was the claimant adversely affected by any act or omission in the rendering of the medical services?

(2) What was the adverse effect?

(3) How did the medical services alter the natural course of the preexisting disorder for which the services were originally rendered?

(4) How did the medical condition existing after performance of the medical services differ from the medical condition which might otherwise have been expected?

(c) In any case in which the answer to one or more of the questions under (b) of this section depends upon the resolution of factual questions which are not the proper subject of expert opinion, the report shall so state and may answer questions based upon hypothetical facts that are fully and completely set out in the opinion. The report shall include copies of all written statements, opinions, or records relied upon by the panel and either a transcription or other record of any oral statements or opinions; shall specify any medical or scientific authority relied upon by the panel; and shall include the results of any physical or mental examination performed on the plaintiff. Each member shall sign the report and his signature constitutes his adoption of all statements and opinions contained in it; however, a member may, instead of signing the report, submit a concurring or dissenting report which complies with the requirements of this subsection, and a member may not attest to any portion of the report as to which he is not qualified to give expert testimony.

(d) No discovery may be undertaken in a case until the report of the expert advisory panel is received. However, the court may relax this prohibition upon a showing of good cause by any party. If the panel has not completed its report within the 30-day period prescribed in (b) of this section, the court may, upon application, grant it an additional 30 days.

(e) The report of the panel and any dissenting or concurring opinion are admissible in evidence to the same extent as though its contents were orally testified to by the person or persons preparing it. The court shall delete any portion that would not be admissible because of lack of foundation for opinion testimony, or otherwise. Either party may submit expert testimony to support or refute the report. The jury shall be instructed in general terms that the report shall be considered and evaluated in the same manner as any other expert testimony. Any member of the panel may be called by any party and may be cross-examined as to the contents of the report or of his dissenting or concurring opinion.

(f) Members of a panel are entitled to travel expenses and per diem in accordance with state law pertaining to members of boards and commissions for all time spent in preparing its report and matters incidental to it. If a panel member is called upon as a witness at trial or upon deposition, he is entitled to payment of an expert witness fee. All expenses incurred by the panel shall be paid by the state. However, in any case in which the court determines that a party has made a patently frivolous claim or a patently frivolous denial of liability, it shall order that all costs of the expert advisory panel be borne by the party making that claim or denial.

Amending Rule 82 to see that this

(g) Parties to the case and their counsel may not initiate communication out of court with members of the panel on the subject matter

of its inquiry and report or cause or solicit others to do so, except through ordinary discovery proceedings.

* Sec. 16. AS 09.55.540 is amended to read:

Sec. 09.55.540. BURDEN OF PROOF. (a) In a malpractice action based on the negligence or wilful misconduct of a health care provider [PHYSICIAN LICENSED UNDER AS 08.64, OR A DENTIST LICENSED UNDER AS 08.-36], the plaintiff has [SHALL HAVE] the burden of proving by a preponderance of the evidence

(1) the degree of knowledge or skill possessed or the degree of care ordinarily exercised under the circumstances, at the time of the act complained of, by health care providers in the field or specialty in which the defendant is practicing [BY PHYSICIANS OR DENTISTS PRACTICING THE SAME SPECIALTY IN SIMILAR COMMUNITIES TO THAT IN WHICH THE DEFENDANT PRACTICES];

(2) that the defendant either lacked this degree of knowledge or skill or failed to exercise this degree of care; and

(3) that as a proximate result of this lack of knowledge or skill or the failure to exercise this degree of care the plaintiff suffered injuries that would not otherwise have been incurred.

(b) In malpractice actions there is [SHALL BE] no presumption of negligence on the part of the defendant.

* Sec. 17. AS 09.55 is amended by adding a new section to read:

Sec. 09.55.546. AWARDS, COLLATERAL SOURCES. (a) In a malpractice action damages shall be awarded according to the principles of the common law. The fact finder in rendering its award for damages shall specify the amount awarded for each category of loss, computing loss of future earnings on a monthly basis. The court may enter a judgment that future damages be paid in whole or in part by periodic payments rather than by a lump sum payment; however, any part of the award which is paid

on periodic basis shall be increased annually in the same proportion as annual increases in the consumer price index for the community in which the claimant resides.

(c) Except when the collateral source is a federal program which by law must seek subrogation, an award to which a claimant is entitled may only cover damages which exceed any amounts received by the claimant as compensation for his injuries from collateral sources, whether private, group, or governmental, and whether contributory or noncontributory, except the death benefit paid under life insurance. Evidence of damages compensation by a collateral source, other than a federal program which must seek subrogation and the death benefit paid under life insurance, shall be credited against the award after the fact finder has rendered its award. Notwithstanding other provisions of state law and except as provided in this subsection, a collateral source does not have a right of subrogation.

* Sec. 18. AS 09.55.550 is amended to read:

Sec. 09.55.550. JURY INSTRUCTIONS. In health care [MEDICAL] malpractice actions the jury shall be instructed that the plaintiff has the burden of proving, by a preponderance of the evidence, the health care provider's negligence or wilful misconduct in accordance with sec. 540 of this chapter [OF THE PHYSICIAN OR DENTIST]. The jury shall be further instructed that injury alone does not raise a presumption of the health care provider's [PHYSICIAN'S OR DENTIST'S] negligence or misconduct.

* Sec. 19. AS 09.55 is amended by adding new sections to read:

Sec. 09.55.554. ORAL CONTRACTS. No cause of action against a health care provider arises for breach of an oral contract to provide a cure or achieve a specific medical result.

Sec. 09.55.556. INFORMED CONSENT. (a) A health care provider is

liable for failure to obtain the informed consent of a patient if the claimant establishes by a preponderance of the evidence that the provider has failed to inform the patient of common risks and reasonable alternatives to the proposed treatment or procedure, and that, but for that failure, the claimant would not have consented to the proposed treatment or procedure.

(b) It is a defense to any action for health care malpractice based upon an alleged failure to obtain such an informed consent that

(1) the risk not disclosed is too commonly known or is too remote to require disclosure;

(2) the patient stated to the health care provider that he would undergo the treatment or procedure regardless of the risk involved, or that he did not want to be informed of the matters to which he would be entitled to be informed;

(3) under the circumstances consent by or on behalf of the patient was not possible; or

(4) the health care provider, after considering all of the attendant facts and circumstances, used reasonable discretion as to the manner and extent to which the alternatives or risks were disclosed to the patient because he reasonably believed that the manner and extent of such a disclosure would reasonably be expected to adversely and substantially affect the patient's condition.

Sec. 09.55.560. DEFINITIONS. In secs. 530 - 560 of this chapter

(1) "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.-72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a

psychologist and a psychological associate licensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital;

(2) "panel" means an expert advisory panel established under sec. 536 of this chapter.

* Sec. 20. AS 09.65.090 is repealed and re-enacted to read:

Sec. 09.65.090. CIVIL LIABILITY FOR EMERGENCY AID. (a) A person, at a hospital or at any other location, who renders emergency care or emergency counseling to an injured, ill, or emotionally distraught person who reasonably appears to the person rendering the aid to be in immediate need of emergency aid in order to avoid serious harm or death is not liable for civil damages as a result of an act or omission in rendering emergency aid.

(b) This section does not preclude liability for civil damages as a result of gross negligence or reckless or intentional misconduct.

* Sec. 21 AS 18.20 is amended by adding new sections to read:

Sec. 18.20.045. INSURANCE REQUIRED. Every hospital, as a condition of licensure, shall submit to the department and maintain evidence of insurance against liability to inpatients and outpatients for malpractice issued by the Health Care Providers Indemnity Corporation, in amounts of not less than $200,000 per occurrence, and an aggregate liability per year of $1,000,000 minimum, and an additional $20,000 for each bed over 50 for which the hospital is licensed.

Sec. 18.20.075. RISK MANAGEMENT. (a) To be eligible for a license each hospital shall have in operation an internal risk management program which shall

(1) investigate the frequency and causes of adverse incidents in hospitals which cause injury to patients;

(2) develop and implement measures to minimize the risk of

injury to patients from adverse incidents; in developing these measures each hospital shall take into account recommendations of the Health Care Providers Indemnity Corporation, its medical staff, private underwriters, industry standards, experience of other hospitals, and recommendations of licensing boards of other health care providers; and

(3) analyze patient grievances which relate to patient care.

(b) The department shall adopt by regulation and submit to the legislative administrative regulation review committee prior to implementation standards for risk management programs in hospitals in the state which may vary according to the size of the hospital, the type of care offered by the hospital, and other factors found relevant by the department.

* Sec. 22. AS 18 is amended by adding a new chapter to read:

CHAPTER 23. HEALTH CARE SERVICES INFORMATION.

Sec. 18.23.010. LIMITATION ON LIABILITY FOR PERSONS PROVIDING INFORMATION TO REVIEW ORGANIZATION. (a) No person providing information to a review organization is subject to action for damages or other relief by reason of having furnished that information, unless the information is false and the person providing the information knew or had reason to know the information was false.

(b) No privilege of confidentiality arising from a physician-patient relationship may be invoked to withhold pertinent information from review by a review organization.

Sec. 18.23.020. LIMITATION ON LIABILITY FOR MEMBERS OF REVIEW ORGANIZATIONS. No person who is a member or employee of, or who acts in an advisory capacity to, or who furnishes counsel or services to, a review organization is liable for damages or other relief in an action brought by a person whose activities have been or are being scrutinized or reviewed by a review organization, by reason of his performance of a

duty, function or activity of the review organization, unless the performance of the duty, function or activity was motivated by malice toward the affected person. No person is liable for damages or other relief in an action by reason of his performance of a duty, function, or activity as a member of a review organization or by reason of a recommendation or action of the review organization when the person acts in the reasonable belief that his action or recommendation is warranted by facts known to him or to the review organization after reasonable efforts to ascertain the facts upon which the review organization's action or recommendation is made.

Sec. 18.23.030. CONFIDENTIALITY OF RECORDS OF REVIEW ORGANIZATION. (a) Except as provided in (b) of this section, all data and information acquired by a review organization, in the exercise of its duties and functions, shall be held in confidence, may not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review organization, and is not subject to subpoena or discovery. Except as provided in (b) of this section, no person described in sec. 20 of this chapter may disclose what transpired at a meeting of a review organization except to the extent necessary to carry out one or more of the purposes of a review organization, and the proceedings and records of a review organization are not subject to discovery or introduction into evidence in a civil action against a health care provider arising out of the matter which is the subject of consideration by the review organization. Information, documents, or records otherwise available from original sources are not immune from discovery or use in a civil action merely because they were presented during proceedings of a review organization, nor may a person who testified before a review organization or who is a member of it be prevented from testifying as to matters within his knowledge, but a witness may not be asked about his testimony

before a review organization or opinions formed by him as a result of its hearings, except as provided in (b) of this section.

(b) Testimony, documents, proceedings, records, and other evidence adduced before a review organization that are otherwise inaccessible under this section may be obtained by a health care provider who claims that denial is unreasonable or may be obtained under subpoena or discovery proceedings brought by a plaintiff who claims that information provided to a review organization was false and claims that the person providing the information knew or had reason to know the information was false.

(c) Nothing in this chapter prevents a person whose conduct or competence has been reviewed under this chapter from obtaining, for the purpose of appellate review of the action of the review organization, any testimony, documents, proceedings, records and other evidence adduced before the review organization.

Sec. 18.23.040. PENALTY FOR VIOLATION. Other than as authorized by sec. 30 of this chapter, a disclosure of data and information acquired by a review committee or of what transpired at a review meeting is a misdemeanor and punishable under AS 11.05.010.

Sec. 18.23.050. PROTECTION OF PATIENT. Nothing in this chapter relieves a person of liability which he has incurred or may incur to a person as a result of furnishing health care to the patient.

Sec. 18.23.060. PARTIES BOUND BY REVIEW. When a review organization reviews matters under sec. 70(5)(H) of this chapter no party is bound by a ruling of the organization in a controversy, dispute or question unless he agrees in advance, either specifically or generally, to be bound by the ruling.

Sec. 18.23.070. DEFINITIONS. In this chapter, unless the context otherwise requires,

(1) "administrative staff" means the staff of a hospital or clinic;

(2) "health care" means professional services rendered by a health care provider or an employee of a health care provider, and services furnished by a sanatorium, rest home, nursing home, boarding home or other institution for the hospitalization or care of human beings;

(3) "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.-77; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital;

(4) "professional service" means service rendered by a health care provider of the type he is licensed to render;

(5) "review organization" means a hospital governing body or a committee whose membership is limited to health care providers and administrative staff, except where otherwise provided for by state or federal law, and which is established by a hospital, by a clinic, by one or more state or local associations of health care providers, by an organization of health care providers from a particular area or medical institution, or by a professional standards review organization established under 42 U.S.C., sec. 1320(c)(1) et seq., to gather and review information relating to the care and treatment of patients for the purposes of

(A) evaluating and improving the quality of health care

rendered in the area or medical institution;

(B) reducing morbidity or mortality;

(C) obtaining and disseminating statistics and information relative to the treatment and prevention of diseases, illness and injuries;

(D) developing and publishing guidelines showing the norms of health care in the area or medical institution;

(E) developing and publishing guidelines designed to keep the cost of health care within reasonable bounds;

(F) reviewing the quality or cost of health care services provided to enrollees of health maintenance organizations;

(G) acting as a professional standards review organization under 42 U.S.C., sec. 1320(c)(1) et seq.;

(H) reviewing, ruling on, or advising on controversies, disputes or questions between

(i) a health insurance carrier or health maintenance organization and one or more of its insured or enrollees;

(ii) a professional licensing board, acting under its powers of discipline or license revocation or suspension, and a health care provider licensed by it when the matter is referred to a review organization by the professional licensing board;

(iii) a health care provider and his patients concerning diagnosis, treatment or care, or a charge or fee;

(iv) a health care provider and a health insurance carrier or health maintenance organization concerning a charge or fee for health care services provided to an insured or enrollee; or

(v) a health care provider or his patients and the federal or a state or local government, or an agency of the federal or a state or local government;

(I) acting on the recommendation of a credential review committee or a grievance committee.

* Sec. 23. AS 21 is amended by adding a new chapter to read:

CHAPTER 88. HEALTH CARE PROVIDERS INSURANCE.

ARTICLE 1. PURPOSE.

Sec. 21.88.010. PURPOSE OF CHAPTER. It is the purpose of this chapter to provide a means of assuring all health care providers continuous, affordable and adequate insurance against liability for medical negligence by concentrating all such insurance in one entity and to distribute equitably the cost of the insurance among the health care providers insured.

ARTICLE 2. INDEMNITY CORPORATION.

Sec. 21.88.020. CORPORATION CREATED. There is created the Alaska Health Care Providers Indemnity Corporation which is a public corporation having a legal existence independent of and separate from the state. Obligations issued by the corporation do not constitute a debt liability or obligation of the state or a pledge of full faith and credit of the state.

Sec. 21.88.030. CORPORATION BOARD OF GOVERNORS. (a) The corporation shall exercise its powers through a board of governors which shall be appointed by the director as provided in (b) of this section.

(b) The appointments to the board of governors shall be Alaska residents as follows:

(1) two members of the Alaska State Medical Association appointed from a list of no less than five persons recommended by the governing board of that association; one of the members appointed shall

be engaged in group practice in a clinic of six or more physicians licensed in the state;

(2) one member of the Alaska State Hospital Association appointed from a list of no less than three persons recommended by the governing board of that association;

(3) two professionals in the insurance field;

(4) two persons who are neither health care providers nor affiliated with the insurance industry.

(c) The term of office of each governor is three years, except that the director shall designate three initially appointed governors to serve for one year and two initially appointed governors to serve for two years.

(d) Upon the expiration of the term of a governor, the director shall appoint a successor who shall be from the same class described in (b) of this section as the governor whose term has expired.

(e) Upon a governor's early resignation, death or inability to serve, the director shall appoint a successor from the same class defined in (b) of this section as the terminating governor, who shall serve for the unexpired term.

(f) The director or his designee is not a voting member of the board of governors but shall be notified by the board of and have the right to attend and participate in all meetings and proceedings of the board.

(g) Members of the board of governors receive $100 per day when the board meets, and travel expenses as allowed by law.

Sec. 21.38.040. CORPORATION PLAN OF OPERATION. (a) Within 30 days after the effective date of this chapter, the board of governors shall prepare and submit to the director for approval a plan of operation which provides for the fair, reasonable and equitable administra-

tion of the affairs of the corporation and the discharge of the purposes for which it is created. The plan and any amendments of it become effective upon the director's approval. If the board of governors has failed to submit a plan of operation, or if at any subsequent time the board of governors fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate a plan of operation or amendments which are necessary or advisable to effectuate the provisions of this chapter. Adoption of the plan is not subject to the Administrative Procedure Act (AS 44.62).

(b) The plan of operation shall

(1) establish the procedures by which all the powers and duties of the corporation specified in sec. 50 of this chapter shall be performed;

(2) establish procedures for handling assets and discharging liabilities of the corporation;

(3) establish regular places and times for meetings of the board of governors;

(4) establish procedures for records to be kept of all financial transactions of the corporation, its agents, and the board of governors;

(5) establish procedures for awarding contracts to carry out the provisions of this chapter;

(6) establish the procedures for issuing contracts of insurance as provided in sec. 50 of this chapter and for the determination of rates;

(7) contain additional provisions necessary or proper for the execution of the powers and duties of the corporation.

Sec. 21.88.050. POWERS AND DUTIES OF THE CORPORATION. (a) The corporation shall

(1) issue to all health care providers who pay the premiums for it a contract on an occurrence basis indemnifying the health care provider and his employees who are health care providers against loss by reason of liability and agreeing to tender on behalf of the health care provider and his employees who are health care providers a defense of the health care provider in a proceeding brought under AS 09.55.530 - 09.55.560; the limit of liability shall be no less than the minimum liability coverage required to be maintained as stated in AS 08.64.21, and AS 18.20.045; the contract shall cover the defense against but need not indemnify a claim for punitive damages; the contract shall cover claims against health care providers

(A) that arise out of professional services performed by the health care provider during the period for which the premium is paid; and

(B) at the option of the health care provider, and for an additional premium, that arise out of services performed by the health care provider after December 31, 1974 for any period in which the health care provider had no malpractice insurance, except that coverage will not be provided for a claim already filed or of which the health care provider has or reasonably should have had notice at the time retroactive insurance was purchased;

(2) charge a premium for the protection provided by the contracts issued under (1) of this subsection which shall be determined by the board of governors in accordance with sec. 70 of this chapter and subject to the approval of the director;

(3) comply with or be subject to AS 21.06.090, 21.06.120, 21.06.140, 21.06.160, 21.06.250; AS 21.09.180, 21.09.190, 21.09.200, 21.09.250, 21.09.280; AS 21.12.020(b), (c), (d), and (e); and chs. 18, 21, 24, and 36 of this title;

(4) carry out the obligations of the contracts issued under (1) of this subsection by defending all covered claims made against insured health care providers and by paying all liabilities which are finally adjudicated against the insured health care provider or which may in the opinion of the corporation reasonably be expected to be finally adjudicated against the health care provider to the extent of the contract obligation;

(5) provide coverage to health care providers for liability under AS 09.55.530 - 09.55.560 in excess of the minimum limits required for licensure as a health care provider, but limited to $1,000,000 for individual health care providers and $5,000,000 for hospitals, if there is a finding by the director that this coverage is unavailable at a reasonable cost and that this coverage can be made available at a reasonable cost through the corporation; if this paragraph is implemented, each health care provider obtaining excess coverage up to these amounts shall obtain it from the corporation, and the corporation may procure reinsurance for all the risks incurred by contracts issued under this paragraph from the private market.

(b) The corporation may

(1) employ or retain persons, individual or corporate, to discharge its obligations and shall pay, by way of salary, wage, fee, or commission, reasonable compensation for those services; employees of the corporation are not considered state employees;

(2) provide coverage to health care providers for other hazards including malpractice liability insurance for other licensed health care providers employed by the physician or hospital [if there is a finding by the director that this coverage is otherwise unavailable by reason of the operation of the corporation;]

(3) borrow funds from the revolving loan fund established

under sec. 110 of this chapter when necessary for the corporation to maintain adequate reserves; loans from the fund shall be repaid within four years after the loan is made at an annual interest rate of seven percent; ~~and~~ (~~through~~ from prospective ~~rate~~ premium increases;)

(4) negotiate and become a party to those contracts as are necessary to carry out the purposes of the corporation;

(5) sue or be sued in the name of the corporation;

(6) negotiate and become a party to contracts for management services for the corporation;

(7) provide risk management advice and services to hospitals;

(8) perform all other acts necessary and proper to effectuate the corporation.

Sec. 21.88.060. STATISTICS. The corporation shall collect, maintain and report information concerning claims against health care providers. All such information shall be on forms prescribed by the director and shall be sufficient to enable a proper determination of losses for rate making and to identify causes and sources of loss for loss control. No less often than annually the corporation shall report to the director, which report shall be kept available to the public, the number and amount of claims filed, reserved, paid, settled and adjudicated during the year, the premiums paid to, and the expenses incurred by the corporation during the year. The director may require that supplemental reports include the names of insured health care providers and the claimants; however, no reports which become publicly available may include the names of health care providers or claimants or information that will permit by inference the identity of specific health care providers or claimants. All information shall be made available to the appropriate licensing boards or agencies.

Sec. 21.88.070. RATES. Rates and rating plans used by the corpora-

tion for the policies issued shall be determined for each category of health care provider in accordance with all of the following:

(1) rates for physicians shall be set as a function of the physician's medical revenue; [in this paragraph medical revenue means the physician's revenue from the practice of medicine as reported when paying the tax levied under AS 43.70;]

(2) rates for hospitals shall be set as a function of the number of permanent beds in the hospital; Average rate of occupancy

(3) a minimum rate may be set for each category of health care provider or discipline or classification within the license category;

(4) rates may not be excessive; rates are excessive if, after a period of time and with respect to an amount of gross premium which are actuarially credible, the premiums exceed losses incurred by the corporation, including losses paid, reserves for claims reported and unpaid, reserves for claims incurred during the policy period and not reported but reasonably expected to be reported within three years after the date of the incident, and reasonable expenses for the operation of the corporation;

(5) rates may not be inadequate; rates are inadequate if, based on available actuarial data, the premiums to be paid by the health care providers are or may reasonably be expected to be insufficient to pay for losses incurred by the corporation, including claims paid, reserves for claims reported and unpaid, reserves for claims incurred during the policy year and not reported but reasonably expected to be reported within three years after the date of the incident, and reasonable expenses for the operation of the corporation;

(6) rates shall be adjusted at least as often as annually;

(7) rates for any policy year shall be calculated to include

the adjustment for actual experience of the corporation as developed for the preceding four policy years;

(8) in considering losses to be incurred, changes in the law and national, regional and local trends in medical negligence awards may be considered;

(9) income from investment of reserves shall be considered;

(10) disciplines and classifications within the license categories of health care providers shall be considered;

(11) individual risk underwriting factors shall be considered;

(12) ~~an~~ amounts necessary sufficient to repay any loan obligation shall be considered.

Sec. 21.88.080. REQUIRED INSURANCE; CANCELLATION. The corporation shall provide insurance to all health care providers otherwise eligible for licensure under AS 08.64 and AS 18.20. The corporation may provide for installment payment of premiums in which event each installment is due by the date specified. The corporation may cancel any of its policies in the event of nonpayment of any premium or installment on a premium or other charge by mailing or delivering to the insured at the address shown on the policy and to the agency of the state issuing the insured's license written notice stating when, not less than 10 days after notice is received by the insured, the cancellation is effective.

ARTICLE 3. LOAN FUND.

Sec. 21.88.110. FUND ESTABLISHED. (a) There is in the Department of Commerce and Economic Development a medical malpractice liability revolving loan fund to be administered by the director of insurance.

(b) Loans shall be made from the fund to the corporation upon certification by the director that a loan is necessary for the corporation to maintain adequate reserves or for initial costs of operation. If a loan is made to the corporation from the fund, the corporation shall issue a note to the fund pledging the premiums collected in the

future as security for the loan.

(c) Loans from the fund shall be repaid by the corporation within four years at an annual interest rate of seven per cent.

(d) The director may sell [or transfer] at par value to the Department of Revenue the notes held by the Department of Commerce and Economic Development as security for loans made under this section. The Department of Revenue shall purchase all the notes offered until the current principal amount of the notes purchased and held by the Department of Revenue equals $5,000,000.

ARTICLE 4. GENERAL PROVISIONS.

Sec. 21.88.300. DEFINITIONS. As used in this chapter,

(1) "corporation" means the Health Care Providers Indemnity Corporation;

(2) "director" means the director of the division of insurance for the State of Alaska;

(3) "fund" means the medical malpractice liability revolving loan fund;

(4) "health care provider" means a physician licensed under AS 08.64 and a hospital as defined in AS 18.20.130, including a hospital or health care facility owned or operated by the state or one or more of its political subdivisons;

(5) "occurrence basis insurance" is insurance against claims arising during the period of the policy coverage.

* Sec. 24. AS 08.64.365 is repealed.

* Sec. 25. This Act takes effect 30 days after enactment.

(1.) Ad Damnum Clause - Calif. has it
(2.) Advance Payment

Original sponsor: Rules Committee by request of the Governor

Offered: 2/24/76

IN THE HOUSE BY THE JUDICIARY COMMITTEE

CS FOR HOUSE BILL NO. 574

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to liability for the provision of health care services; changing the Alaska Supreme Court's Rules of Civil Procedure; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 08.01.050 is amended by adding a new paragraph to read:

(19) provide investigative services to the boards established under chs. 20, 32, 36, 64, 68, 71, 72, 80, 84, and 86 of this title, for the purpose of assisting those boards in matters of professional discipline.

Add public member to each Board

* Sec. 2. AS 08.20 is amended by adding new sections to read:

Sec. 08.20.115. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance against liability to patients for chiropractic malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require all persons licensed under this chapter to obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for chiropractors is impairing the delivery of chiropractic services to the public.

Sec. 08.20.175. LIMITS OR CONDITIONS ON LICENSE; REPRIMAND. (a)

Give immunity to Boards

apply this concept to

add health

In addition to action under sec. 170 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice chiropractic should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 3. AS 08.32 is amended by adding new sections to read:

Sec. 08.32.015. INCURANCE REQUIRED. (a) To be eligible for an active licence under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $100,000 per occurrence and $300,000 aggregate liability per year. This requirement is satisfied if the person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require all persons licensed under this chapter to obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for dental hygienists is impairing the delivery of dental hygienists' services to the public.

Sec. 08.32.165. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 160 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice dental hygiene should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any

action taken by the board under this section.

* Sec. 4. AS 08.36 is amended by adding new sections to read:

Sec. 08.36.115. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance against liability to patients for dental malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require all persons licensed under this chapter to obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for dentists is impairing the delivery of dentist services to the public.

Sec. 08.36.325. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 320 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice dentistry should be limited or conditioned or the practitioner disciplined, the board may censure, on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 5. AS 08.64 is amended by adding new sections to read:

Sec. 08.64.215. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance issued by the Health Care Providers Indemnity Corporation against liability to patients for medical malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This

Add to all provisions

requirement is satisfied if a person's employer maintains insurance for him from the Health Care Providers Indemnity Corporation in the required amounts.

(b) The director of insurance or his designee may waive the requirement in (a) of this section for a person if that person furnishes satisfactory evidence of his having other insurance providing coverage in amounts not less than those specified in (a) of this section. No waiver granted under this subsection may extend beyond the normal expiration date of the person's insurance policy or January 1, 1977, whichever occurs first.

Sec. 08.64.312. CONTINUING EDUCATION REQUIREMENTS. (a) The board shall promote a high degree of competence in the practice of medicine by requiring every physician licensed in the state to fulfill continuing education requirements.

(b) Before a license may be renewed the licensee shall submit evidence to the board that continuing education requirements prescribed by regulations adopted by the board have been met.

(c) The board may exempt a physician from the requirements of (b) of this section upon an application by him giving evidence satisfactory to the board that he is unable to comply with the requirements because of extenuating circumstances. However, no person may be exempted from more than 15 hours of continuing education in a five-year period.

Sec. 08.64.325. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 330 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 6. AS 08.68 is amended by adding new sections to read:

Sec. 08.68.165. INSURANCE REQUIRED. (a) To be eligible for an active license as a nurse under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $100,000 per occurrence and $300,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require all persons licensed under this chapter to obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for nurses is impairing the delivery of nurse services to the public.

Sec. 08.68.275. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 270 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice nursing should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 7. AS 08.71 is amended by adding new sections to read:

Sec. 08.71.085. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $100,000 per occurrence and $300,000 aggregate liability per year. This

requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require that all persons licensed under this chapter obtain the insurance required under (a) of this section if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for dispensing opticians is impairing delivery of the services of dispensing opticians to the public.

Sec. 08.71.175. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 170 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice as a dispensing optician under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by procedure or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 8. AS 08.72 is amended by adding new sections to read:

Sec. 08.72.115. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $100,000 per occurrence and $300,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require all persons licensed under this chapter to obtain insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for optometrists is impairing delivery of optome-

trist services to the public.

Sec. 08.72.255. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under secs. 240 and 250 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice optometry under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 9. AS 80.80 is amended by adding new sections to read:

Sec. 08.80.115. INSURANCE REQUIRED. (a) To be eligible for active registration as a pharmacist, a person must maintain insurance against liability to patients for malpractice in limits of not less than $100,000 per occurrence and $300,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require that all persons licensed under this chapter obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for pharmacists is impairing delivery of pharmacist services to the public.

Sec. 08.80.265. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 260 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice pharmacy under this chapter should be limited or conditioned or the practitioner disciplined, the board may

reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 10. AS 08.84 is amended by adding new sections to read:

Sec. 08.84.035. INSURANCE REQUIRED. (a) To be eligible for active registration as a physical therapist under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $100,000 per occurrence and $300,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require that all persons licensed under this chapter obtain the insurance required in (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for physical therapists is impairing delivery of physical therapist services to the public.

Sec. 08.84.185. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 180 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice physical therapy should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 11. AS 08.86.120 is amended to read:

Sec. 08.86.120. ENTITLEMENT TO LICENSURE A person who passes the examination given by the board <u>and possesses the insurance required by</u>

sec. 125 of this chapter is entitled to be licensed as a psychologist.

* Sec. 12. AS 08.86.160 is amended to read:

Sec. 08.86.160. ASSOCIATES: ENTITLEMENT TO LICENSURE. A person who passes the examination given by the board and who possesses insurance in accordance with sec. 125 of this chapter is entitled to be licensed as a psychological associate.

* Sec. 13. AS 08.86 is amended by adding new sections to read:

Sec. 08.86.125. INSURANCE REQUIRED. (a) To be eligible for active licensure as a psychologist under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $100,000 per occurrence and $300,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require all persons licensed under this chapter to obtain insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for psychologists is impairing the delivery of psychologist services to the public.

Sec. 08.86.220. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) Upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice psychology or as a psychological associate under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure place on probation, restrict practice by time, specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 14. AS 09.55.530 is repealed and re-enacted to read:

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ARTICLE 6. MALPRACTICE ACTIONS.

Sec. 09.55.530. DECLARATION OF PURPOSE. The legislature finds that the health of the people is threatened by curtailment of health care services due to the difficulty in obtaining adequate malpractice insurance at a reasonable cost. It is the purpose of secs. 530 - 560 of this chapter to protect the health and safety of the people of this state by establishing procedural aids for handling malpractice claims which will help ensure the ready availability of adequate insurance at a reasonable cost and which will be fair to all parties concerned.

* Sec. 15. AS 09.55 is amended by adding a new section to read:

Sec. 09.55.536. EXPERT ADVISORY PANEL. (a) In any action for damages due to personal injury or death based upon the provision of professional services by a health care provider, the court shall establish a three-person expert advisory panel in accordance with this section. When the action is filed the court shall, by order, determine the professions or specialties to be represented on the expert advisory panel and shall advise each party of the professions or specialties to be represented, giving the parties the opportunity to object or make suggestions. The court may in its discretion conduct other preliminary proceedings relative to the composition of the panel as it considers appropriate.

(b) The expert advisory panel may compel the attendance of witnesses, interview the parties and physically examine the injured person if alive, consult with the specialists or learned works they consider appropriate, and compel the production of and examine all relevant hospital, medical, or other records or materials relating to the health care treatment. The panel may meet in camera, but shall maintain a record of any testimony or oral statements of witnesses, and shall keep copies of all written statements and opinions it receives. Not less

than 30 days after selection of the panel, it shall make a written report to the parties and to the court, substantially answering the following questions in addition to any other question which the court puts to the panel:

(1) Was the claimant adversely affected by any act or omission in the rendering of the medical services?

(2) What was the adverse effect?

(3) How did the medical services alter the natural course of the preexisting disorder for which the services were originally rendered?

(4) How did the medical condition existing after performance of the medical services differ from the medical condition which might otherwise have been expected?

(c) In any case in which the answer to one or more of the questions under (b) of this section depends upon the resolution of factual questions which are not the proper subject of expert opinion, the report shall so state and may answer questions based upon hypothetical facts that are fully and completely set out in the opinion. The report shall include copies of all written statements, opinions, or records relied upon by the panel and either a transcription or other record of any oral statements or opinions; shall specify any medical or scientific authority relied upon by the panel; and shall include the results of any physical or mental examination performed on the plaintiff. Each member shall sign the report and his signature constitutes his adoption of all statements and opinions contained in it; however, a member may, instead of signing the report, submit a concurring or dissenting report which complies with the requirements of this subsection, and a member may not attest to any portion of the report as to which he is not qualified to give expert testimony.

(d) No discovery may be undertaken in a case until the report of the expert advisory panel is received. However, the court may relax this prohibition upon a showing of good cause by any party. If the panel has not completed its report within the 30-day period prescribed in (b) of this section, the court may, upon application, grant it an additional 30 days.

(e) The report of the panel and any dissenting or concurring opinion are admissible in evidence to the same extent as though its contents were orally testified to by the person or persons preparing it. The court shall delete any portion that would not be admissible because of lack of foundation for opinion testimony, or otherwise. Either party may submit expert testimony to support or refute the report. The jury shall be instructed in general terms that the report shall be considered and evaluated in the same manner as any other expert testimony. Any member of the panel may be called by any party and may be cross-examined as to the contents of the report or of his dissenting or concurring opinion.

(f) Members of a panel are entitled to travel expenses and per diem in accordance with state law pertaining to members of boards and commissions for all time spent in preparing its report and matters incidental to it. If a panel member is called upon as a witness at trial or upon deposition, he is entitled to payment of an expert witness fee. All expenses incurred by the panel shall be paid by the state. However, in any case in which the court determines that a party has made a patently frivolous claim or a patently frivolous denial of liability, it shall order that all costs of the expert advisory panel be borne by the party making that claim or denial.

(g) Parties to the case and their counsel may not initiate communication out of court with members of the panel on the subject matter

of its inquiry and report or cause or solicit others to do so, except through ordinary discovery proceedings.

* Sec. 16. AS 09.55.540 is amended to read:

Sec. 09.55.540. BURDEN OF PROOF. (a) In a malpractice action based on the negligence or wilful misconduct of a health care provider [PHYSICIAN LICENSED UNDER AS 08.64, OR A DENTIST LICENSED UNDER AS 08.36], the plaintiff has [SHALL HAVE] the burden of proving by a preponderance of the evidence

(1) the degree of knowledge or skill possessed or the degree of care ordinarily exercised under the circumstances, at the time of the act complained of, by health care providers in the field or specialty in which the defendant is practicing [BY PHYSICIANS OR DENTISTS PRACTICING THE SAME SPECIALTY IN SIMILAR COMMUNITIES TO THAT IN WHICH THE DEFENDANT PRACTICES];

(2) that the defendant either lacked this degree of knowledge or skill or failed to exercise this degree of care; and

(3) that as a proximate result of this lack of knowledge or skill or the failure to exercise this degree of care the plaintiff suffered injuries that would not otherwise have been incurred.

(b) In malpractice actions there is [SHALL BE] no presumption of negligence on the part of the defendant.

* Sec. 17. AS 09.55 is amended by adding a new section to read:

Sec. 09.55.546. AWARDS, COLLATERAL SOURCES. (a) In a malpractice action damages shall be awarded according to the principles of the common law. The fact finder in rendering its award for damages shall specify the amount awarded for each category of loss, computing loss of future earnings on a monthly basis. The court may enter a judgment that future damages be paid in whole or in part by periodic payments rather than by a lump sum payment; however, any part of the award which is paid

exhaustion of benefits problem

on periodic basis shall be increased annually in the same proportion as annual increases in the consumer price index for the community in which the claimant resides.

(c) Except when the collateral source is a federal program which by law must seek subrogation, an award to which a claimant is entitled may only cover damages which exceed any amounts received by the claimant as compensation for his injuries from collateral sources, whether private, group, or governmental, and whether contributory or noncontributory, except the death benefit paid under life insurance. Evidence of damages compensation by a collateral source, other than a federal program which must seek subrogation and the death benefit paid under life insurance, shall be credited against the award after the fact finder has rendered its award. Notwithstanding other provisions of state law and except as provided in this subsection, a collateral source does not have a right of subrogation.

* Sec. 18. AS 09.55.550 is amended to read:

Sec. 09.55.550. JURY INSTRUCTIONS. In health care [MEDICAL] malpractice actions the jury shall be instructed that the plaintiff has the burden of proving, by a preponderance of the evidence, the health care provider's negligence or wilful misconduct in accordance with sec. 540 of this chapter [OF THE PHYSICIAN OR DENTIST]. The jury shall be further instructed that injury alone does not raise a presumption of the health care provider's [PHYSICIAN'S OR DENTIST'S] negligence or misconduct.

* Sec. 19. AS 09.55 is amended by adding new sections to read:

Sec. 09.55.554. ORAL CONTRACTS. No cause of action against a health care provider arises for breach of an oral contract to provide a cure or achieve a specific medical result.

Sec. 09.55.556. INFORMED CONSENT. (a) A health care provider is

liable for failure to obtain the informed consent of a patient if the claimant establishes by a preponderance of the evidence that the provider has failed to inform the patient of common risks and reasonable alternatives to the proposed treatment or procedure, and that, but for that failure, the claimant would not have consented to the proposed treatment or procedure.

(b) It is a defense to any action for health care malpractice based upon an alleged failure to obtain such an informed consent that

(1) the risk not disclosed is too commonly known or is too remote to require disclosure;

(2) the patient stated to the health care provider that he would undergo the treatment or procedure regardless of the risk involved, or that he did not want to be informed of the matters to which he would be entitled to be informed;

(3) under the circumstances consent by or on behalf of the patient was not possible; or

(4) the health care provider, after considering all of the attendant facts and circumstances, used reasonable discretion as to the manner and extent to which the alternatives or risks were disclosed to the patient because he reasonably believed that the manner and extent of such a disclosure would reasonably be expected to adversely and substantially affect the patient's condition.

Sec. 09.55.560. DEFINITIONS. In secs. 530 - 560 of this chapter

(1) "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a

Not a real problem

psychologist and a psychological associate licensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital;

(2) "panel" means an expert advisory panel established under sec. 536 of this chapter.

* Sec. 20. AS 09.65.090 is repealed and re-enacted to read:

Sec. 09.65.090. CIVIL LIABILITY FOR EMERGENCY AID. (a) A person, at a hospital or at any other location, who renders emergency care or emergency counseling to an injured, ill, or emotionally distraught person who reasonably appears to the person rendering the aid to be in immediate need of emergency aid in order to avoid serious harm or death is not liable for civil damages as a result of an act or omission in rendering emergency aid.

(b) This section does not preclude liability for civil damages as a result of gross negligence or reckless or intentional misconduct.

* Sec. 21. AS 18.20 is amended by adding new sections to read:

Sec. 18.20.045. INSURANCE REQUIRED. Every hospital, as a condition of licensure, shall submit to the department and maintain evidence of insurance against liability to inpatients and outpatients for malpractice issued by the Health Care Providers Indemnity Corporation, in amounts of not less than $200,000 per occurrence, and an aggregate liability per year of $1,000,000 minimum, and an additional $20,000 for each bed over 50 ~~for which the hospital is licensed~~.

Sec. 18.20.075. RISK MANAGEMENT. (a) To be eligible for a license each hospital shall have in operation an internal risk management program which shall

(1) investigate the frequency and causes of adverse incidents in hospitals which cause injury to patients;

(2) develop and implement measures to minimize the risk of

Add waiver for existing policy

injury to patients from adverse incidents; in developing these measures each hospital shall take into account recommendations of the Health Care Providers Indemnity Corporation, its medical staff, private underwriters, industry standards, experience of other hospitals, and recommendations of licensing boards of other health care providers; and

(3) analyze patient grievances which relate to patient care.

(b) The department shall adopt by regulation and submit to the legislative administrative regulation review committee prior to implementation standards for risk management programs in hospitals in the state which may vary according to the size of the hospital, the type of care offered by the hospital, and other factors found relevant by the department.

* Sec. 22. AS 18 is amended by adding a new chapter to read:

CHAPTER 23. HEALTH CARE SERVICES INFORMATION.

Sec. 18.23.010. LIMITATION ON LIABILITY FOR PERSONS PROVIDING INFORMATION TO REVIEW ORGANIZATION. (a) No person providing information to a review organization is subject to action for damages or other relief by reason of having furnished that information, unless the information is false and the person providing the information knew or had reason to know the information was false.

(b) No privilege of confidentiality arising from a physician-patient relationship may be invoked to withhold pertinent information from review by a review organization.

Sec. 18.23.020. LIMITATION ON LIABILITY FOR MEMBERS OF REVIEW ORGANIZATIONS. No person who is a member or employee of, or who acts in an advisory capacity to, or who furnishes counsel or services to, a review organization is liable for damages or other relief in an action brought by a person whose activities have been or are being scrutinized or reviewed by a review organization, by reason of his performance of a

duty, function or activity of the review organization, unless the performance of the duty, function or activity was motivated by malice toward the affected person. No person is liable for damages or other relief in an action by reason of his performance of a duty, function, or activity as a member of a review organization or by reason of a recommendation or action of the review organization when the person acts in the reasonable belief that his action or recommendation is warranted by facts known to him or to the review organization after reasonable efforts to ascertain the facts upon which the review organization's action or recommendation is made.

Sec. 18.23.030. CONFIDENTIALITY OF RECORDS OF REVIEW ORGANIZATION. (a) Except as provided in (b) of this section, all data and information acquired by a review organization, in the exercise of its duties and functions, shall be held in confidence, may not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review organization, and is not subject to subpoena or discovery. Except as provided in (b) of this section, no person described in sec. 20 of this chapter may disclose what transpired at a meeting of a review organization except to the extent necessary to carry out one or more of the purposes of a review organization, and the proceedings and records of a review organization are not subject to discovery or introduction into evidence in a civil action against a health care provider arising out of the matter which is the subject of consideration by the review organization. Information, documents, or records otherwise available from original sources are not immune from discovery or use in a civil action merely because they were presented during proceedings of a review organization, nor may a person who testified before a review organization or who is a member of it be prevented from testifying as to matters within his knowledge, but a witness may not be asked about his testimony

before a review organization or opinions formed by him as a result of its hearings, except as provided in (b) of this section.

(b) Testimony, documents, proceedings, records, and other evidence adduced before a review organization that are otherwise inaccessible under this section may be obtained by a health care provider who claims that denial is unreasonable or may be obtained under subpoena or discovery proceedings brought by a plaintiff who claims that information provided to a review organization was false and claims that the person providing the information knew or had reason to know the information was false.

(c) Nothing in this chapter prevents a person whose conduct or competence has been reviewed under this chapter from obtaining, for the purpose of appellate review of the action of the review organization, any testimony, documents, proceedings, records and other evidence adduced before the review organization.

Sec. 18.23.040. PENALTY FOR VIOLATION. Other than as authorized by sec. 30 of this chapter, a disclosure of data and information acquired by a review committee or of what transpired at a review meeting is a misdemeanor and punishable under AS 11.05.010.

Sec. 18.23.050. PROTECTION OF PATIENT. Nothing in this chapter relieves a person of liability which he has incurred or may incur to a person as a result of furnishing health care to the patient.

Sec. 18.23.060. PARTIES BOUND BY REVIEW. When a review organization reviews matters under sec. 70(5)(H) of this chapter no party is bound by a ruling of the organization in a controversy, dispute or question unless he agrees in advance, either specifically or generally, to be bound by the ruling.

Sec. 18.23.070. DEFINITIONS. In this chapter, unless the context otherwise requires,

(1) "administrative staff" means the staff of a hospital or clinic;

(2) "health care" means professional services rendered by a health care provider or an employee of a health care provider, and services furnished by a sanatorium, rest home, nursing home, boarding home or other institution for the hospitalization or care of human beings;

(3) "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.-72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital;

(4) "professional service" means service rendered by a health care provider of the type he is licensed to render;

(5) "review organization" means a hospital governing body or a committee whose membership is limited to health care providers and administrative staff, except where otherwise provided for by state or federal law, and which is established by a hospital, by a clinic, by one or more state or local associations of health care providers, by an organization of health care providers from a particular area or medical institution, or by a professional standards review organization established under 42 U.S.C., sec. 1320(c)(1) et seq., to gather and review information relating to the care and treatment of patients for the purposes of

(A) evaluating and improving the quality of health care

rendered in the area or medical institution;

(B) reducing morbidity or mortality;

(C) obtaining and disseminating statistics and information relative to the treatment and prevention of diseases, illness and injuries;

(D) developing and publishing guidelines showing the norms of health care in the area or medical institution;

(E) developing and publishing guidelines designed to keep the cost of health care within reasonable bounds;

(F) reviewing the quality or cost of health care services provided to enrollees of health maintenance organizations;

(G) acting as a professional standards review organization under 42 U.S.C., sec. 1320(c)(1) et seq.;

(H) reviewing, ruling on, or advising on controversies, disputes or questions between

(i) a health insurance carrier or health maintenance organization and one or more of its insured or enrollees;

(ii) a professional licensing board, acting under its powers of discipline or license revocation or suspension, and a health care provider licensed by it when the matter is referred to a review organization by the professional licensing board;

(iii) a health care provider and his patients concerning diagnosis, treatment or care, or a charge or fee;

(iv) a hea[illegible]re provider and a health insurance carrier or health m[illegible]ance organization concerning a charge or fee for health [illegible] services provided to an insured or enrollee; or

(v) a health care provider or his patients and the federal or a state or local government, or an agency of the federal or a state or local government;

(I) acting on the recommendation of a credential review committee or a grievance committee.

* Sec. 23. AS 21 is amended by adding a new chapter to read:

CHAPTER 88. HEALTH CARE PROVIDERS INSURANCE.

ARTICLE 1. PURPOSE.

Sec. 21.88.010. PURPOSE OF CHAPTER. It is the purpose of this chapter to provide a means of assuring all health care providers continuous, affordable and adequate insurance against liability for medical negligence by concentrating all such insurance in one entity and to distribute equitably the cost of the insurance among the health care providers insured.

ARTICLE 2. INDEMNITY CORPORATION.

Sec. 21.88.020. CORPORATION CREATED. There is created the Alaska Health Care Providers Indemnity Corporation which is a public corporation having a legal existence independent of and separate from the state. Obligations issued by the corporation do not constitute a debt liability or obligation of the state or a pledge of full faith and credit of the state.

Sec. 21.88.030. CORPORATION BOARD OF GOVERNORS. (a) The corporation shall exercise its powers through a board of governors which shall be appointed by the director as provided in (b) of this section.

Appointed by Gov confirmed by Legis.

(b) The appointments to the board of governors shall be Alaska residents as follows:

(1) two members of the Alaska State Medical Association appointed from a list of no less than five persons recommended by the governing board of that association; one of the members appointed shall

say physician

be engaged in group practice in a clinic of six or more physicians licensed in the state;

(2) one member of the Alaska State Hospital Association appointed from a list of no less than three persons recommended by the governing board of that association;

(3) two professionals in the insurance field;

(4) two persons who are neither health care providers nor affiliated with the insurance industry.

(c) The term of office of each governor is three years, except that the director shall designate three initially appointed governors to serve for one year and two initially appointed governors to serve for two years.

(d) Upon the expiration of the term of a governor, the director shall appoint a successor who shall be from the same class described in (b) of this section as the governor whose term has expired.

(e) Upon a governor's early resignation, death or inability to serve, the director shall appoint a successor from the same class defined in (b) of this section as the terminating governor, who shall serve for the unexpired term.

(f) The director or his designee is not a voting member of the board of governors but shall be notified by the board of and have the right to attend and participate in all meetings and proceedings of the board.

(g) Members of the board of governors receive compensation from the corporation of $100 per day when the board meets and necessary travel expenses.

Sec. 21.88.040. CORPORATION PLAN OF OPERATION. (a) Within 30 days after the effective date of this chapter, the board of governors shall prepare and submit to the director for approval a plan of opera-

tion which provides for the fair, reasonable and equitable administration of the affairs of the corporation and the discharge of the purposes for which it is created. The plan and any amendments of it become effective upon the director's approval. If the board of governors has failed to submit a plan of operation, or if at any subsequent time the board of governors fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate a plan of operation or amendments which are necessary or advisable to effectuate the provisions of this chapter. Adoption of the plan is not subject to the Administrative Procedure Act (AS 44.62).

(b) The plan of operation shall

(1) establish the procedures by which all the powers and duties of the corporation specified in sec. 50 of this chapter shall be performed;

(2) establish procedures for handling assets and discharging liabilities of the corporation;

(3) establish regular places and times for meetings of the board of governors;

(4) establish procedures for records to be kept of all financial transactions of the corporation, its agents, and the board of governors;

(5) establish procedures for awarding contracts to carry out the provisions of this chapter;

(6) establish the procedures for issuing contracts of insurance as provided in sec. 50 of this chapter and for the determination of rates;

(7) contain additional provisions necessary or proper for the execution of the powers and duties of the corporation.

Sec. 21.88.050. POWERS AND DUTIES OF THE CORPORATION. (a) The

corporation shall

(1) issue to all health care providers who pay the premiums for it a contract on an occurrence basis indemnifying the health care provider and his employees who are health care providers against loss by reason of liability and agreeing to tender on behalf of the health care provider and his employees who are health care providers a defense of the health care provider in a proceeding brought under AS 09.55.530 - 09.55.560; the limit of liability shall be no less than the minimum liability coverage required to be maintained as stated in AS 08.64.215 and AS 18.20.045; the contract shall cover the defense against but need not indemnify a claim for punitive damages; the contract shall cover claims against health care providers

(A) that arise out of professional services performed by the health care provider during the period for which the premium is paid; and

(B) at the option of the health care provider and for an additional premium, that arise out of services performed by the health care provider after December 31, 1974 for any period in which the health care provider had no malpractice insurance, except that coverage will not be provided for a claim already filed or of which the health care provider has or reasonably should have had notice at the time retroactive insurance was purchased;

(2) charge a premium for the protection provided by the contracts issued under (1) of this subsection which shall be determined by the board of governors in accordance with sec. 70 of this chapter and subject to the approval of the director;

(3) comply with or be subject to AS 21.06.090, 21.06.120, 21.06.140, 21.06.160, 21.06.250; AS 21.09.180, 21.09.190, 21.09.200, 21.09.250, 21.09.280; AS 21.12.020(b), (c), (d), and (e); and chs. 18,

21, 24, and 36 of this title;

(4) carry out the obligations of the contracts issued under (1) of this subsection by defending all covered claims made against insured health care providers and by paying all liabilities which are finally adjudicated against the insured health care provider or which may in the opinion of the corporation reasonably be expected to be finally adjudicated against the health care provider to the extent of the contract obligation;

(5) provide coverage to health care providers for liability under AS 09.55.530 - 09.55.560 in excess of the minimum limits required for licensure as a health care provider, but limited to $1,000,000 for individual health care providers and $5,000,000 for hospitals, if there is a finding by the director that this coverage is unavailable at a reasonable cost and that this coverage can be made available at a reasonable cost through the corporation: if this paragraph is implemented, each health care provider obtaining excess coverage up to these amounts shall obtain it from the corporation, and the corporation may procure reinsurance for all the risks incurred by contracts issued under this paragraph from the private market.

(b) The corporation may

(1) employ or retain persons, individual or corporate, to discharge its obligations and shall pay, by way of salary, wage, fee, or commission, reasonable compensation for those services; employees of the corporation are not considered state employees;

(2) provide coverage to health care providers for other hazards including malpractice liability insurance for other licensed health care providers employed by the physician or hospital;

(3) borrow funds from the revolving loan fund established under sec. 110 of this chapter when necessary for the corporation to

maintain adequate reserves; loans from the fund shall be repaid from prospective premium increases within four years after the loan is made at an annual interest rate of seven per cent;

(4) negotiate and become a party to those contracts as are necessary to carry out the purposes of the corporation;

(5) sue or be sued in the name of the corporation;

(6) negotiate and become a party to contracts for management services for the corporation;

(7) provide risk management advice and services to hospitals;

(8) perform all other acts necessary and proper to effectuate the corporation.

Sec. 21.88.060. STATISTICS. The corporation shall collect, maintain and report information concerning claims against health care providers. All such information shall be on forms prescribed by the director and shall be sufficient to enable a proper determination of losses for rate making and to identify causes and sources of loss for loss control. No less often than annually the corporation shall report to the director, which report shall be kept available to the public, the number and amount of claims filed, reserved, paid, settled and adjudicated during the year, the premiums paid to, and the expenses incurred by the corporation during the year. The director may require that supplemental reports include the names of insured health care providers and the claimants; however, no reports which become publicly available may include the names of health care providers or claimants or information that will permit by inference the identity of specific health care providers or claimants. All information shall be made available to the appropriate licensing boards or agencies.

Sec. 21.88.070. RATES. Rates and rating plans used by the corporation for the policies issued shall be determined for each category of

Add can't be discriminatory

slant rates for rural areas

health care provider in accordance with all of the following:

(1) rates for physicians shall be set as a function of the physician's medical revenue;

(2) rates for hospitals shall be set as a function of the number of permanent beds in the hospital;

(3) a minimum rate may be set for each category of health care provider or discipline or classification within the license category; (A)

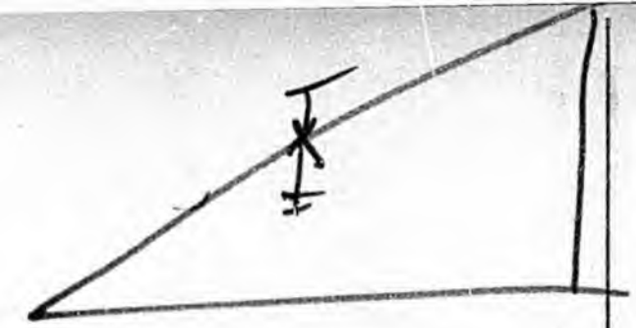
(4) rates may not be excessive; rates are excessive if, after a period of time and with respect to an amount of gross premium which are actuarially credible, the premiums exceed losses incurred by the corporation, including losses paid, reserves for claims reported and unpaid, reserves for claims incurred during the policy period and not reported but reasonably expected to be reported within three years after the date of the incident, and reasonable expenses for the operation of the corporation;

(5) rates may not be inadequate; rates are inadequate if, based on available actuarial data, the premiums to be paid by the health care providers are or may reasonably be expected to be insufficient to pay for losses incurred by the corporation, including claims paid, reserves for claims reported and unpaid, reserves for claims incurred during the policy year and not reported but reasonably expected to be reported within three years after the date of the incident, and reasonable expenses for the operation of the corporation;

(6) rates shall be adjusted at least as often as annually;

(7) rates for any policy year shall be calculated to include the adjustment for actual experience of the corporation as developed for the preceding four policy years;

(8) in considering losses to be incurred, changes in the law



and national, regional and local trends in medical negligence awards may be considered;

(9) income from investment of reserves shall be considered;

(10) disciplines and classifications within the license categories of health care providers shall be considered;

(11) individual risk underwriting factors shall be considered;

(12) amounts sufficient to repay loan obligations shall be considered.

Sec. 21.88.080. REQUIRED INSURANCE; CANCELLATION. The corporation shall provide insurance to all health care providers otherwise eligible for licensure under AS 08.64 and AS 18.20. The corporation may provide for installment payment of premiums in which event each installment is due by the date specified. The corporation may cancel any of its policies in the event of nonpayment of any premium or installment on a premium or other charge by mailing or delivering to the insured at the address shown on the policy and to the agency of the state issuing the insured's license written notice stating when, not less than 10 days after notice is received by the insured, the cancellation is effective.

ARTICLE 3. LOAN FUND.

Sec. 21.88.110. FUND ESTABLISHED. (a) There is in the Department of Commerce and Economic Development a medical malpractice liability revolving loan fund to be administered by the director of insurance.

(b) Loans shall be made from the fund to the corporation upon certification by the director that a loan is necessary for the corporation to maintain adequate reserves or for initial costs of operation. If a loan is made to the corporation from the fund, the corporation shall issue a note to the fund pledging the premiums collected in the future as security for the loan.

(c) Loans from the fund shall be repaid by the corporation within

four years at an annual interest rate of seven per cent.

(d) The director may sell at par value to the Department of Revenue the notes, security instruments and pledge agreements held by the Department of Commerce and Economic Development as security for loans made under this section. The Department of Revenue shall purchase all the notes offered until the current principal amount of the notes purchased and held by the Department of Revenue equals $5,000,000.

ARTICLE 4. GENERAL PROVISIONS.

Sec. 21.88.300. DEFINITIONS. As used in this chapter,

(1) "corporation" means the Health Care Providers Indemnity Corporation;

(2) "director" means the director of the division of insurance for the State of Alaska;

(3) "fund" means the medical malpractice liability revolving loan fund;

(4) "health care provider" means a physician licensed under AS 08.64 and a hospital as defined in AS 18.20.130, including a hospital or health care facility owned or operated by the state or one or more of its political subdivisions; if at any time the director of insurance mandates chiropractors under AS 08.20.115(b), dental hygienists under AS 08.32.015(b), dentists under AS 08.36.115(b), nurses under AS 08.68.-165(b), dispensing opticians under AS 08.71.085(b), optometrists under AS 08.72.115(b), pharmacists under AS 08.80.115(b), physical therapists under AS 08.84.035(b), or psychologists and psychological associates under AS 08.86.125(b) into participation in the corporation, they shall then be considered health care providers for the purposes of this chapter;

Claims Made? (5) "occurrence basis insurance" is insurance against claims arising during the period of the policy coverage.

* Sec. 24. AS 21.18.090 is amended by adding a new paragraph to read:

(5) reserves for the Health Care Providers Indemnity Corporation are to include only reserves for claims reported and unpaid and reserves for claims incurred but not reported but which may reasonably be expected to be reported within three years after the date of occurrence.

* Sec. 25. AS 09.55.536 enacted in sec. 15 of this Act, has the effect of changing the Alaska Supreme Court's Rules of Civil Procedure, by requiring the submission of each health care malpractice action to a panel of experts.

* Sec. 26. AS 08.64.365 is repealed.

* Sec. 27. This Act takes effect 30 days after enactment.

5/1/76

Original Sponsor: Rules Committee by request of the Governor

IN THE HOUSE BY THE FREE CONFERENCE COMMITTEE

FREE CONFERENCE CS FOR SENATE CS FOR CS FOR HOUSE BILL NO. 574

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to health care; changing the Alaska Supreme Court's Rules of Civil Procedure; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 08.01.050 is amended by adding a new paragraph to read:

(19) provide investigative services to the boards established under chs. 20, 32, 36, 64, 68, 71, 72, 80, 84, and 86 of this title, for the purpose of assisting those boards in matters of professional discipline.

* Sec. 2. AS 08.20.010 is amended to read:

Sec. 08.20.010. CREATION AND MEMBERSHIP OF BOARD OF CHIROPRACTIC EXAMINERS. There is created the Board of Chiropractic Examiners consisting of <u>five</u> [THREE] members appointed by the governor.

* Sec. 3. AS 08.20.020 is amended to read:

Sec. 08.20.020. MEMBERS OF BOARD. <u>Three members</u> [EACH MEMBER] of the board shall be [A] licensed chiropractic <u>physicians who</u> [PHYSICIAN AND SHALL] have practiced chiropractic in this state not less than two years. <u>Two members of the board shall be persons with no direct financial interest in the health care industry.</u> Each member serves without pay but is entitled to per diem and travel expenses allowed by law.

* Sec. 4. AS 08.20.030 is repealed and re-enacted to read:

Sec. 08.20.030. MEMBERS TERMS, VACANCIES. Members serve for staggered terms of three years. The terms of the public members of the board may not expire at the same time. Vacancies on the board shall be

filled for the unexpired term.

* Sec. 5. AS 08.20 is amended by adding a new section to read:

Sec. 08.20.115. MALPRACTIC INSURANCE. If medical malpractice insurance for chiropractors becomes unavailable on the voluntary market and the director of insurance finds, after public hearing, that the unavailability is impairing the delivery of chiropractic services to the public, the director of insurance may require all persons licensed under this chapter to carry malpractice insurance and to purchase their insurance from the Medical Indemnity Corporation of Alaska established under AS 21.88. If a finding of unavailability of insurance on the voluntary market and impairment of services has been made under this section, purchase of medical malpractice insurance from the Medical Indemnity Corporation of Alaska is a condition of licensure under this chapter. The provisions of this section are satisfied if the licensee's employer maintains insurance for him from the Medical Indemnity Corporation of Alaska.

* Sec. 6. AS 08.20 is amended by adding a new section to read:

Sec. 08.20.175. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 170 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education or health the authority to practice chiropractic should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure or facility, or require ~~continuing~~ additional education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 7. AS 08.32 is amended by adding new sections to read:

Sec. 08.32.015. MALPRACTICE INSURANCE. If medical malpractice insurance for dental hygienists becomes unavailable on the voluntary market and the director of insurance finds, after public hearing, that the unavailability is impairing the delivery of dental hygiene services

to the public, the director of insurance may require all persons licensed under this chapter to carry malpractice insurance and to purchase their insurance from the Medical Indemnity Corporation of Alaska established under AS 21.88. If a finding of unavailability of insurance on the voluntary market and impairment of services has been made under this section, purchase of medical malpractice insurance from the Medical Indemnity Corporation of Alaska is a condition of licensure under this chapter. The provisions of this section are satisfied if the licensee's employer maintains insurance for him from the Medical Indemnity Corporation of Alaska.

Sec. 08.32.165. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 160 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education or health the authority to practice dental hygiene should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require ~~continuing~~ additional education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 8. AS 08.36.010 is amended to read:

Sec. 08.36.010. CREATION AND MEMBERSHIP OF BOARD. There is created the Board of Dental Examiners, referred to in this chapter as the board, consisting of seven [FIVE] members. Five members [EACH MEMBER] shall be [A CITIZEN OF THE UNITED STATES AND A] qualified resident dentists who have [HAS] been engaged in the practice of dentistry in the state for five years immediately preceding [HIS] appointment, one member shall be a dental hygienist licensed under AS 08.32, and one member with no direct financial interest in the health care industry.

* Sec. 9. AS 08.36.020 is amended to read:

Sec. 08.36.020. APPOINTMENT AND TERM OF SERVICE OF MEMBERS. Members of the board are appointed by the governor, subject to confirmation by the legislature in joint session [ASSEMBLED]. Each

board member serves for a term of five years, and until his successor is appointed and qualified. The term begins on February 1. An appointment to a vacancy is for the unexpired term. [APPOINTMENTS SHALL BE MADE FROM A LIST OF NAMES RECOMMENDED BY THE ALASKA DENTAL SOCIETY. THE LIST SHALL BE SUPPLIED AT LEAST 30 DAYS BEFORE THE BEGINNING OF A TERM AND NOT MORE THAN 60 DAYS AFTER THE OCCURRENCE OF A VACANCY. THE LIST SHALL CONTAIN AT LEAST TWO RECOMMENDED NAMES FOR EACH APPOINTMENT. THE GOVERNOR SHALL MAKE THE APPOINTMENT WITHIN 30 DAYS AFTER RECEIVING THE LIST.]

* Sec. 10. AS 08.36 is amended by adding new sections to read:

Sec. 08.36.315. MALPRACTICE INSURANCE. If medical malpractice insurance for dentists becomes unavailable on the voluntary market and the director of insurance finds, after public hearing, that the unavailability is impairing the delivery of dental services to the public, the director of insurance may require all persons licensed under this chapter to carry malpractice insurance and to purchase their insurance from the Medical Indemnity Corporation of Alaska established under AS 21.88. If a finding of unavailability of insurance on the voluntary market and impairment of services has been made under this section, purchase of medical malpractice insurance from the Medical Indemnity Corporation of Alaska is a condition of licensure under this chapter. The provisions of this section are satisfied if the licensee's employer maintains insurance for him from the Medical Indemnity Corporation of Alaska.

Sec. 08.36.325. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 320 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health, the authority to practice dentistry should be limited or conditioned or the practitioner disciplined, the board may censure, place on probation, restrict practice by specialty, procedure, or facility, or require ~~continuing education~~ additional education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 11. AS 08.64.010 is amended to read:

Sec. 08.64.010. CREATION AND MEMBERSHIP OF STATE MEDICAL BOARD. The governor shall appoint a board of medical examiners, to be known as the State Medical Board, consisting of five licensed physicians, residing in as many separate Alaska judicial districts as possible, and two persons with no direct financial interest in the health care industry. [EACH MEMBER SHALL BE CHOSEN FROM A PANEL OF THREE, FOR EACH VACANCY, SUBMITTED TO THE GOVERNOR BY THE ALASKA STATE MEDICAL ASSOCIATION.]

* Sec. 12. AS 08.64.020 is amended to read:

Sec. 08.64.020. STATE MEDICAL BOARD TERM OF OFFICE. Members shall be appointed for a term of four years, subject to confirmation by a majority of the members of the legislature in joint session, and shall hold office until their successors are appointed and qualified. The terms of the public members of the board shall be staggered so that they do not expire at the same time.

* Sec. 13. AS 08.64.090 is amended to read:

Sec. 08.64.090. QUORUM. Four [THREE] members of the board constitute a quorum for the transaction of all business properly before the board.

* Sec. 14. AS 08.64 is amended by adding new sections to read:

Sec. 08.64.215. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person shall maintain insurance issued by the Medical Indemnity Corporation of Alaska against liability to patients for medical malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him

from the Medical Indemnity Corporation of Alaska in the required amounts.

(b) The director of insurance or his designee shall waive the requirement in (a) of this section for a person if that person furnishes satisfactory evidence of his having other insurance providing coverage in amounts not less than those specified in (a) of this section. No waiver granted under this subsection may extend beyond the normal expiration date of the person's insurance policy or January 1, 1977, whichever occurs first.

Sec. 08.64.312. CONTINUING EDUCATION REQUIREMENTS. (a) The board shall promote a high degree of competence in the practice of medicine by requiring every physician licensed in the state to fulfill continuing education requirements.

(b) Before a license may be renewed the licensee shall submit evidence to the board that continuing education requirements prescribed by regulations adopted by the board have been met.

(c) The board may exempt a physician from the requirements of (b) of this section upon an application by him giving evidence satisfactory to the board that he is unable to comply with the requirements because of extenuating circumstances. However, no person may be exempted from more than 15 hours of continuing education in a five-year period.

Sec. 08.64.325. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 330 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require ~~continuing~~ additional education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 15. AS 08.68.010 is amended to read:

Sec. 08.68.010. CREATION AND MEMBERSHIP OF BOARD OF NURSING. There is created a Board of Nursing, consisting of seven [FIVE] members appointed by the governor. One member shall be currently involved in institutional nursing service, one member in community or public health nursing and two members in basic or continuing nursing education, [AND] one nurse at large, and two persons who have no direct financial interest in the health care industry.

* Sec. 16. AS 08.68.020 is repealed and re-enacted to read:

Sec. 08.68.020. TERM OF OFFICE. Members serve staggered terms of five years and until their successors are appointed. The terms of the public members on the board shall be set so that they do not expire at the same time. Vacancies on the board shall be filled for the unexpired term.

* Sec. 17. AS 08.68.060 is amended to read:

Sec. 08.68.060. QUALIFICATIONS OF BOARD MEMBERS. The five members [EACH MEMBER] of the board who are nurses shall be [A CITIZEN OF THE UNITED STATES, A RESIDENT OF THE STATE, AND A] licensed professional nurses [NURSE] in the state, and [MEMBERS] shall have been actively engaged in nursing for not less than four years before appointment, two years of which were within the five years preceding appointment.

* Sec. 18. AS 08.68 is amended by adding new sections to read:

Sec. 08.68.165. MALPRACTICE INSURANCE. If medical malpractice insurance for nurses becomes unavailable on the voluntary market and the director of insurance finds, after public hearing, that the unavailability is impairing the delivery of nursing services to the public, the director of insurance may require all persons licensed under this chapter to carry malpractice insurance and to purchase their insurance from the Medical Indemnity Corporation of Alaska established under AS 21.88.

If a finding of unavailability of insurance on the voluntary market and impairment of services has been made under this section, purchase of medical malpractice insurance from the Medical Indemnity Corporation of Alaska is a condition of licensure under this chapter. The provisions of this section are satisfied if the licensee's employer maintains insurance for him from the Medical Indemnity Corporation of Alaska.

Sec. 08.68.275. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 270 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice nursing should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require ~~continuing~~ additional education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 19. AS 08.71.020 is amended to read:

Sec. 08.71.020. MEMBERSHIP OF BOARD; SOURCE OF APPOINTMENTS; TERM OF OFFICE. The board consists of seven [FIVE] persons appointed by the governor. ~~Members serve staggered terms~~ of three years. The terms of the public members of the board shall be set so that they do not expire at the same time. [THE GOVERNOR SHALL APPOINT BOARD MEMBERS FROM A LIST OF QUALIFIED OPTICIANS PREPARED BY THE ASSOCIATION OF OPTICIANS IN THE STATE AND SUBMITTED AT LEAST 30 DAYS BEFORE JULY 1, 1973, AT LEAST 30 DAYS BEFORE THE EXPIRATION OF A TERM AND NOT MORE THAN 60 DAYS AFTER A VACANCY OCCURS IN AN UNEXPIRED TERM. THE LIST SHALL CONTAIN NOT LESS THAN TWO RECOMMENDED CANDIDATES FOR EACH APPOINTMENT. THE GOVERNOR SHALL MAKE APPOINTMENTS WITHIN 30 DAYS AFTER RECEIVING THE LIST. THE TERM OF OFFICE OF EACH MEMBER IS THREE YEARS. HOWEVER, OF THE FIRST MEMBERS OF THE BOARD, ONE SHALL BE APPOINTED FOR A ONE-YEAR TERM, TWO FOR TWO-YEAR TERMS, AND TWO FOR THREE-YEAR TERMS.] Vacancies on the board shall be filled for the unexpired term [IN THE SAME MANNER AS

ORIGINAL APPOINTMENT].

* Sec. 20. AS 08.71.030 is amended to read:

Sec. 08.71.030. QUALIFICATIONS OF BOARD MEMBERS. Five [A] board members [MEMBER] shall be [A] licensed, practicing dispensing opticians [OPTICIAN] residing in the state. Two shall be persons with no direct financial interest in the health care industry.

* Sec. 21. AS 08.71 is amended by adding new sections to read:

Sec. 08.71.085. MALPRACTICE INSURANCE. If medical malpractice insurance for opticians becomes unavailable on the voluntary market and the director of insurance finds, after public hearing, that the unavailability is impairing the delivery of optician services to the public, the director of insurance may require all persons licensed under this chapter to carry malpractice insurance and to purchase their insurance from the Medical Indemnity Corporation of Alaska established under AS 21.88. If a finding of unavailability of insurance on the voluntary market and impairment of services has been made under this section, purchase of medical malpractice insurance from the Medical Indemnity Corporation of Alaska is a condition of licensure under this chapter. The provisions of this section are satisfied if the licensee's employer maintains insurance for him from the Medical Indemnity Corporation of Alaska.

Sec. 08.71.175. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 170 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice as a dispensing optician under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by procedure, or facility, or require ~~continuing~~ education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 22. AS 08.72.020 is amended to read:

Sec. 08.72.020. MEMBERSHIP OF BOARD AND TERMS OF OFFICE. The board consists of five [THREE] persons, appointed by the governor. Members serve staggered terms of three years. The terms of the public members of the board shall be set so that they do not expire at the same time. [THE TERM OF EACH MEMBER IS THREE YEARS. ONE MEMBER ONLY IS APPOINTED EACH YEAR, EXCEPT WHEN VACANCIES FOR UNEXPIRED TERMS ARE FILLED.]

* Sec. 23. AS 08.72.040 is repealed and re-enacted to read:

Sec. 08.72.040. QUALIFICATIONS. Three board members shall be licensed, practicing optometrists who have been residents for at least three years. Two shall be persons who have no direct financial interest in the health care industry.

* Sec. 24. AS 08.72 is amended by adding new sections to read:

Sec. 08.72.115. MALPRACTICE INSURANCE. If medical malpractice insurance for optometrists becomes unavailable on the voluntary market and the director of insurance finds, after public hearing, that the unavailability is impairing the delivery of optometrist services to the public, the director of insurance may require all persons licensed under this chapter to carry malpractice insurance and to purchase their insurance from the Medical Indemnity Corporation of Alaska established under AS 21.88. If a finding of unavailability of insurance on the voluntary market and impairment of services has been made under this section, purchase of medical malpractice insurance from the Medical Indemnity Corporation of Alaska is a condition of licensure under this chapter. The provisions of this section are satisfied if the licensee's employer maintains insurance for him from the Medical Indemnity Corporation of Alaska.

Sec. 08.72.255. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under secs. 240 and 250 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice optometry under this chapter should be limited or conditioned or the practitioner

disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require ~~continuing~~ additional education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 25. AS 08.80.010 is amended to read:

Sec. 08.80.010. CREATION AND MEMBERSHIP OF BOARD OF PHARMACY. There is created the Board of Pharmacy, composed of seven [FIVE] members five [EACH] of whom shall be pharmacists [A PHARMACIST] licensed in the state who have [HAS] been actively engaged in the practice of pharmacy in the state for a period of three years immediately preceding their [HIS] appointment. Two shall be persons with no direct financial interest in the health care industry. Whenever possible, the board shall include at least one member from each judicial district.

* Sec. 26. AS 08.80.020 is amended to read:

Sec. 08.80.020. TERM OF OFFICE. Members of the board are appointed by the governor, and confirmed by the legislature in joint session, for overlapping terms of five years, or until their successors are appointed and qualified. The terms of the public members shall be staggered so that they do not expire at the same time. An appointment to fill a vacancy is for the unexpired term. The term of office begins on April 1 of each year.

* Sec. 27. AS 08.80.070 is amended to read:

Sec. 08.80.070. QUORUM. Four [THREE] members constitute a quorum for the transaction of business. However, when the board meets for the purpose of examining applications for registration, three [TWO] members of the board constitute a quorum.

* Sec. 28. AS 08.80 is amended by adding new sections to read:

Sec. 08.80.115. MALPRACTICE INSURANCE. If medical malpractice

insurance for pharmacists becomes unavailable on the voluntary market and the director of insurance finds, after public hearing, that the unavailability is impairing the delivery of pharmacist services to the public, the director of insurance may require all persons licensed under this chapter to carry malpractice insurance and to purchase their insurance from the Medical Indemnity Corporation of Alaska established under AS 21.88 If a finding of unavailability of insurance on the voluntary market and impairment of services has been made under this section, purchase of medical malpractice insurance from the Medical Indemnity Corporation of Alaska is a condition of licensure under this chapter. The provisions of this section are satisfied if the licensee's employer maintains insurance for him from the Medical Indemnity Corporation of Alaska.

Sec. 08.80.265. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 260 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice pharmacy under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require ~~continuing~~ education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 29. AS 08.84 is amended by adding new sections to read:

Sec. 08.84.035. MALPRACTICE INSURANCE. If medical malpractice insurance for physical therapists becomes unavailable on the voluntary market and the director of insurance finds, after public hearing, that the unavailability is impairing the delivery of physical therapist services to the public, the director of insurance may require all persons licensed under this chapter to carry malpractice insurance and to purchase their insurance from the Medical Indemnity Corporation of Alaska established under AS 21.88.

If a finding of unavailability of insurance on the voluntary market and impairment of services has been made under this section, purchase of medical malpractice insurance from the Medical Indemnity Corporation of Alaska is a condition of licensure under this chapter. The provisions of this section are satisfied if the licensee's employer maintains insurance for him from the Medical Indemnity Corporation of Alaska.

Sec. 08.84.185. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 180 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education or health the authority to practice physical therapy should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require ~~continuing~~ additional education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 30. AS 08.86.010 is amended to read:

Sec. 08.86.010. CREATION AND MEMBERSHIP OF BOARD. There is created a Board of Psychologist and Psychological Associate Examiners. It consists of three licensed psychologists, and two persons who have no direct financial interest in the health care industry.

* Sec. 31. AS 08.86.020 is amended to read:

Sec. 08.86.020. APPOINTMENT AND TERM OF OFFICE. Members of the board are appointed by the governor and confirmed by the legislature for staggered terms of three years. The terms of the public members shall be set so that they do not expire at the same time. A member serves at the pleasure of the governor.

* Sec. 32. AS 08.86 is amended by adding new sections to read:

Sec. 08.86.125. MALPRACTICE INSURANCE. If medical malpractice insurance for psychologists or psychological associates becomes unavailable on the voluntary market and the director of insurance finds, after public hearing, that the unavailability is impairing the delivery of

psychologist or psychological associate services to the public, the director of insurance may require all persons licensed under this chapter to carry malpractice insurance and to purch e their insurance from the Medical Indemnity Corporation of Alaska established under AS 21.88. If a finding of unavailability of insurance on the voluntary market and impairment of services has been made under this section, purchase of medical malpractice insurance from the Medical Indemnity Corporation of Alaska is a condition of licensure under this chapter. The provisions of this section are satisfied if the licensee's employer maintains insurance for him from the Medical Indemnity Corporation of Alaska.

Sec. 08.86.220. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) Upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice psychology or as a phsychological associate under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by time, specialty, procedure, or facility, or require ~~continuing~~ additional education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 33. AS 09.55 is amended by adding new sections to read:

Sec. 09.55.535. VOLUNTARY ARBITRATION. (a) A patient and any health care provider may execute an agreement to submit to arbitration any dispute, controversy, or issue arising out of care or treatment by the health care provider during the period that the agreement is in force or that has already arisen between the parties.

(b) An agreement to arbitrate executed before care or treatment is provided shall clearly provide in bold print on the face of the agreement that execution of the agreement by the patient is not a prerequisite to receiving care or treatment. If this subsection is not complied with by the health care provider, the agreement to arbitrate is void. The form to be used shall be approved in advance by the attorney general of the state to assure it fairly informs both parties to the agreement

and properly protects their interests.

(c) The agreement shall provide that the person receiving health care may revoke the agreement within 30 ~~calendar~~ days after execution by notifying the health care provider in writing. A health care provider may not revoke the agreement after its execution. The period for revocation shall be tolled during any period that the person receiving health care is physically unable to execute a revocation.(d)An arbitration agreement entered into by the parents or legal guardian of a minor person receiving health care is binding upon the minor person.

(~~d~~e) Each admission to a hospital shall be treated as separate and distinct for the purposes of an agreement to arbitrate, but a person receiving outpatient care from a hospital or clinic or a member of a health maintenance organization may execute an agreement with the hospital which provides for continuation of the agreement for a continuing program of treatment or during continued membership.

(~~e~~f) Upon the filing of a malpractice claim which is subject to an agreement to arbitrate, the claim shall be submitted to an arbitration board. The arbitration board shall consist of three arbitrators: one arbitrator designated by the claimant or claimants, one arbitrator designated by the health care provider or providers against whom the claim is made, and a third arbitrator designated by mutual agreement who shall serve as chairperson of the board. If the parties cannot agree on the third person, the court will provide a choice of three or more persons who might serve as chairperson of the arbitration board, which shall be from a list of qualified arbitrators furnished by the attorney general. Claimant or claimants together and health care provider or providers together may each strike one or more names, so after each side has done so at least one name remains, providing a basis for the final selection by the court.

(~~f~~g) The attorney general shall prepare a list of persons consisting of lawyers or other persons qualified to serve as chairperson of an arbitration board. They shall be selected on basis of their technical expertise, judicial temperament, and capability of impartially acting on malpractice claims. The attorney general shall submit a list of at

least three names whenever requested to do so by the court along with detailed biographical information on each person listed.

(g) Each member of the arbitration board shall receive reasonable compensation to be paid by the court based on the extent and duration of services rendered. The court shall pay the costs of expert witnesses called by the board and the costs of expert witnesses called by the parties to the arbitration up to a maximum of three witnesses for each side and $150 per day for each expert witness.

(h) The arbitration board may appoint an expert advisory panel, with the powers of the expert advisory panel under sec. 536 of this chapter, to advise the board on the medical facts of the case.

(i) The court shall specify the shortest practical deadline for completion of the work of the arbitration board, taking into account all the circumstances and the nature of the case.

(j) The provisions of the Uniform Arbitration Act, AS 09.43.010 - 09.43.180, apply to arbitrations under this section if they do not conflict with the provisions of this section; arbitrations under this section shall be conducted in accordance with procedures established by any rules of court which may be adopted and according to provisions of secs. 540 - 548 and 554 - 560 of this chapter, and AS 09.65.090 - 09.65.100.

Sec. 09.55.536. EXPERT ADVISORY PANEL. (a) In any action for damages due to personal injury or death based upon the provision of professional services by a health care provider when the parties have not agreed to arbitration of the claim under sec. 535 of this chapter, the court shall appoint a three-person expert advisory panel unless the court decides that an expert advisory opinion is not necessary for a decision in the case. When the action is filed the court shall, by order, determine the professions or specialties to be represented on the expert advisory panel, giving the parties the opportunity to object or make suggestions.

(b) The expert advisory panel may compel the attendance of witnesses, interview the parties, physically examine the injured person if alive, consult with the specialists or learned works they consider appropriate, and compel the production of and examine all relevant hospital, medical, or other records or materials relating to the health care in issue. The panel may meet in camera, but shall maintain a record of any testimony or oral statements of witnesses, and shall keep copies of all written statements it receives.

(c) Not more than 30 days after selection of the panel, it shall make a written report to the parties and to the court, answering the questions ~~submitted to the panel by the court and~~, in the court's discretion, ~~any of the following questions:~~ And any additional questions

(1) Was the care which is the subject of the litigation appropriate to the complaint or condition for which the plaintiff sought or was brought to medical care?

(2) Was the care administered in accordance with appropriate medical standards?

(3) Did an injury arise from the medical care?

(4) What is the nature and the extent of the medical injury?

(5) If a medical injury had not occurred, how would the plaintiff's condition differ from the plaintiff's present condition?

(d) In any case in which the answer to one or more of the questions submitted to the panel depends upon the resolution of factual questions which are not the proper subject of expert opinion, the report shall so state and may answer questions based upon hypothetical facts that are fully set out in the opinion. The report shall include copies of all written statements, opinions, or records relied upon by the panel and either a transcription or other record of any oral statements or opinions; shall specify any medical or scientific authority relied upon by the panel; and shall include the results of any physical or mental

examination performed on the plaintiff. Each member shall sign the report and his signature constitutes his adoption of all statements and opinions contained in it; however, a member may, instead of signing the report, submit a concurring or dissenting report which complies with the requirements of this subsection. A member may not attest to any portion of the report as to which he is not qualified to give expert testimony.

(e) The report of the panel with any dissenting or concurring opinion is admissible in evidence to the same extent as though its contents were orally testified to by the person or persons preparing it. The court shall delete any portion that would not be admissible because of lack of foundation for opinion testimony, or otherwise. Either party may submit expert testimony to support or refute the report. The jury shall be instructed in general terms that the report shall be considered and evaluated in the same manner as any other expert testimony. Any member of the panel may be called by any party and may be cross-examined as to the contents of the report or of his dissenting or concurring opinion.

(f) No discovery may be undertaken in a case until the report of the expert advisory panel is received. However, the court may relax this prohibition upon a showing of good cause by any party. If the panel has not completed its report within the 30-day period prescribed in (b) of this section, the court may, upon application, grant it an additional 30 days.

(g) Members of a panel are entitled to travel expenses and per diem in accordance with state law pertaining to members of boards and commissions for all time spent in preparing its report. If a panel member is called upon as a witness at trial or upon deposition, he is entitled to payment of an expert witness fee, which may not exceed $150 per day. All expenses incurred by the panel shall be paid by the

court. However, in any case in which the court determines that a party has made a patently frivolous claim or a patently frivolous denial of liability, it shall order that all costs of the expert advisory panel be borne by the party making that claim or denial.

(h) Parties to the case and their counsel may not initiate communication out of court with members of the panel on the subject matter of its inquiry and report or cause or solicit others to do so, except through ordinary discovery proceedings.

* Sec. 34. AS 09.55.540 is amended to read:

Sec. 09.55.540. BURDEN OF PROOF. (a) In a malpractice action based on the negligence or wilful misconduct of a health care provider [PHYSICIAN LICENSED UNDER AS 08.64, OR A DENTIST LICENSED UNDER AS 08.-36], the plaintiff has [SHALL HAVE] the burden of proving by a preponderance of the evidence

(1) the degree of knowledge or skill possessed or the degree of care ordinarily exercised under the circumstances, at the time of the act complained of, by health care providers in the field or specialty in which the defendant is practicing [BY PHYSICIANS OR DENTISTS PRACTICING THE SAME SPECIALTY IN SIMILAR COMMUNITIES TO THAT IN WHICH THE DEFENDANT PRACTICES];

(2) that the defendant either lacked this degree of knowledge or skill or failed to exercise this degree of care; and

(3) that as a proximate result of this lack of knowledge or skill or the failure to exercise this degree of care the plaintiff suffered injuries that would not otherwise have been incurred.

(b) In malpractice actions there is [SHALL BE] no presumption of negligence on the part of the defendant.

* Sec. 35. AS 09.55 is amended by adding new sections to read:

Sec. 09.55.546. ADVANCE PAYMENTS. In an action to recover damages

under secs. 530 - 560 of this chapter, no advance payment made by the defendant health care provider or his professional liability insurer to or on behalf of the plaintiff is admissible as evidence or may be construed as an admission of liability for injuries or damages suffered by the plaintiff; however, a final award in favor of the plaintiff shall be reduced to the extent of any advance payment. The advance payment shall inure to the exclusive benefit of the defendant or the insurer making the payment.

Sec. 09.55.547. AD DAMNUM. In a cause of action against a health care provider for malpractice, the complaint or any other pleadings may not contain an ad damnum clause or monetary amount claimed against the defendant health care provider, except as necessary for jurisdictional purposes.

Sec. 09.55.548. AWARDS, COLLATERAL SOURCE. (a) Damages shall be awarded in accordance with principles of the common law. The fact finder in a malpractice action shall render any award for damages by category of loss. The court may enter a judgment that future damages be paid in whole or in part by periodic payments rather than by a lump-sum payment; the judgment shall include, if necessary, other provisions to assure that funds will be available as periodic payments become due. Insurance from an authorized insurer as defined in AS 21.90.080 or from the Medical Indemnity Corporation of Alaska is sufficient assurance that funds will be available. Any part of the award which is paid on a periodic basis shall be adjusted annually according to changes in the consumer price index in the community where the claimant resides. In this subsection, future damages includes damages for future medical treatment, care or custody, loss of future earnings, or loss of bodily function of the claimant.

(b) Except when the collateral source is a federal program which by law must seek subrogation and except death benefits paid under life insurance, a claimant may only recover damages from the defendant which

exceed amounts received by the claimant as compensation for his injuries from collateral sources, whether private, group or governmental, and whether contributory or noncontributory. Evidence of collateral sources, other than a federal program which must by law seek subrogation and the death benefit paid under life insurance, is admissible after the fact finder has rendered an award. The court may take into account the value of claimant's rights to coverage exhausted or depleted by payment of these collateral benefits by adding back a reasonable estimate of their probable value, or by earmarking and holding for possible periodic payment under (a) of this section that amount of the award that would otherwise have been deducted, to see if the impairment of claimant's rights actually takes place in the future.

* Sec. 36. AS 09.55.550 is amended to read:

Sec. 09.55.550. JURY INSTRUCTIONS. In health care [MEDICAL] malpractice actions the jury shall be instructed that the plaintiff has the burden of proving [, BY A PREPONDERANCE OF THE EVIDENCE,] the health care provider's negligence or wilful misconduct in accordance with the standard of proof specified in sec. 540 of this chapter [OF THE PHYSICIAN OR DENTIST]. The jury shall be further instructed that injury alone does not raise a presumption of the health care provider's [PHYSICIAN'S OR DENTIST'S] negligence or misconduct.

* Sec. 37. AS 09.55 is amended by adding new sections to read:

Sec. 09.55.554. ORAL CONTRACTS. No cause of action against a health care provider arises for breach of an oral contract to provide a cure or achieve a specific medical result.

Sec. 09.55.556. INFORMED CONSENT. (a) A health care provider is liable for failure to obtain the informed consent of a patient if the claimant establishes by a preponderance of the evidence that the provider has failed to inform the patient of the common risks and reasonable alternatives to the proposed treatment or procedure, and that but

for that failure the claimant would not have consented to the proposed treatment or procedure.

(b) It is a defense to any action for medical malpractice based upon an alleged failure to obtain informed consent that

(1) the risk not disclosed is too commonly known or is too remote to require disclosure;

(2) the patient stated to the health care provider that he would undergo the treatment or procedure regardless of the risk involved or that he did not want to be informed of the matters to which he would be entitled to be informed;

(3) under the circumstances consent by or on behalf of the patient was not possible; or

(4) the health care provider after considering all of the attendant facts and circumstances used reasonable discretion as to the manner and extent that the alternatives or risks were disclosed to the patient because he reasonably believed that a full disclosure would have a substantially adverse effect on the patient's condition.

Sec. 09.55.560. DEFINITIONS. In secs. 530 - 560 of this chapter

(1) "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.-72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital;

(2) "board" means an arbitration board established under sec. 535 of this chapter;

(3) "panel" means an expert advisory panel established under sec. 536 of this chapter.

* Sec. 38. AS 09.65.090 is repealed and re-enacted to read:

Sec. 09.65.090. CIVIL LIABILITY FOR EMERGENCY AID. (a) A person at a hospital or any other location who renders emergency care or emergency counseling to an injured, ill, or emotionally distraught person who reasonably appears to the person rendering the aid to be in immediate need of emergency aid in order to avoid serious harm or death is not liable for civil damages as a result of an act or omission in rendering emergency aid.

(b) This section does not preclude liability for civil damages as a result of gross negligence or reckless or intentional misconduct.

* Sec. 39. AS 18.20 is amended by adding new sections to read:

Sec. 18.20.045. INSURANCE REQUIRED. (a) Every hospital, as a condition of licensure, shall maintain and submit to the department evidence of insurance against liability to inpatients and outpatients for malpractice issued by the Medical Indemnity Corporation of Alaska, in amounts of not less than $200,000 per occurrence, and an aggregate liability per year of $1,000,000 minimum, and an additional $20,000 for each bed over 50.

(b) The director of insurance or his designee shall waive the requirement in (a) of this section for a hospital if the hospital furnishes satisfactory evidence of having other insurance providing coverage in amounts not less than those specified in (a) of this section. A waiver granted under this subsection may not extend beyond the normal expiration date of the hospital's insurance policy or January 1, 1977, whichever occurs first.

(c) The director of insurance may permit a deductible provision in the policy for a hospital if the hospital

(1) demonstrates to the satisfaction of the director of insurance that without indemnity from any other source the hospital has the financial resources to discharge the maximum potential exposure to the hospital by reason of the deductible provision;

(2) agrees to permit the Medical Indemnity Corporation of Alaska to provide the defense to any claim brought against the hospital if any health care provider insured by the corporation is also involved in the claim and to reimburse the corporation for a pro rata portion of the costs of defense; and

(3) provides the Medical Indemnity Corporation of Alaska with notice of any claim brought against it.

Sec. 18.20.075. RISK MANAGEMENT. (a) To be eligible for a license each hospital shall have in operation an internal risk management program which shall

(1) investigate the frequency and causes of incidents in hospitals which cause injury to patients;

(2) develop and implement measures to minimize the risk of injury to patients; in developing these measures each hospital shall take into account recommendations of the medical staff, the Medical Indemnity Corporation of Alaska, private underwriters, industry standards, experience of other hospitals, and recommendations of licensing boards of other health care providers; and

(3) analyze patient grievances which relate to patient care.

(b) The department shall adopt by regulation standards for the risk management programs in hospitals in the state which may vary according to the size of the hospital, the type of care offered by the hospital, and other factors found relevant by the department. Regulations adopted under this subsection are subject to the Administrative Procedure Act (AS 44.62).

* Sec. 40. AS 18 is amended by adding a new chapter to read:

CHAPTER 23. HEALTH CARE SERVICES INFORMATION.

Sec. 18.23.010. LIMITATION ON LIABILITY FOR PERSONS PROVIDING INFORMATION TO REVIEW ORGANIZATION. (a) No person providing information to a review organization is subject to action for damages or other relief by reason of having furnished that information, unless the information is false and the person providing the information knew or had reason to know the information was false.

(b) No privilege of confidentiality arising from a physician-patient relationship may be invoked to withhold pertinent information from review by a review organization.

Sec. 18.23.020. LIMITATION ON LIABILITY FOR MEMBERS OF REVIEW ORGANIZATIONS. No person who is a member or employee of, or who acts in an advisory capacity to, or who furnishes counsel or services to a review organization is liable for damages or other relief in an action brought by another whose activities have been or are being scrutinized or reviewed by a review organization, by reason of the performance of a duty, function or activity of the review organization, unless the performance of the duty, function or activity was motivated by malice toward the affected person. No person is liable for damages or other relief in an action by reason of his performance of a duty, function, or activity as a member of a review organization or by reason of a recommendation or action of the review organization when the person acts in the reasonable belief that the action or recommendation is warranted by facts known to the person or to the review organization after reasonable efforts to ascertain the facts upon which the review organization's action or recommendation is made.

Sec. 18.23.030. CONFIDENTIALITY OF RECORDS OF REVIEW ORGANIZATION.

(a) Except as provided in (b) of this section, all data and information acquired by a review organization, in the exercise of its duties and functions, shall be held in confidence and may not be disclosed to anyone except to the extent necessary to carry out the purposes of the review organization, and is not subject to subpoena or discovery. Except as provided in (b) of this section, no person described in sec. 20 of this chapter may disclose what transpired at a meeting of a review organization except to the extent necessary to carry out the purposes of a review organization, and the proceedings and records of a review organization are not subject to discovery or introduction into evidence in a civil action against a health care provider arising out of the matter which is the subject of consideration by the review organization. Information, documents, or records otherwise available from original sources are not immune from discovery or use in a civil action merely because they were presented during proceedings of a review organization, nor may a person who testified before a review organization or who is a member of it be prevented from testifying as to matters within his knowledge, but a witness may not be asked about his testimony before a review organization or opinions formed by him as a result of its hearings, except as provided in (b) of this section.

(b) Testimony, documents, proceedings, records, and other evidence adduced before a review organization that are otherwise inaccessible under this section may be obtained by a health care provider who claims that denial is unreasonable, or may be obtained under subpoena or discovery proceedings brought by a plaintiff who claims that information provided to a review organization was false and claims that the person providing the information knew or had reason to know the information was false.

(c) Nothing in this chapter prevents a person whose conduct or

competence has been reviewed under this chapter from obtaining, for the purpose of appellate review of the action of the review organization, any testimony, documents, proceedings, records and other evidence adduced before the review organization.

Sec. 18.23.040. PENALTY FOR VIOLATION. Other than as authorized by sec. 30 of this chapter, a disclosure of data and information acquired by a review committee or of what transpired at a review meeting is a misdemeanor and punishable under AS 11.05.010.

Sec. 18.23.050. PROTECTION OF PATIENT. Nothing in this chapter relieves a person of liability which he has incurred or may incur to a person as a result of furnishing health care to the patient.

Sec. 18.23.060. PARTIES BOUND BY REVIEW. When a review organization reviews matters under sec. 70(5)(H) of this chapter no party is bound by a ruling of the organization in a controversy, dispute or question unless he agrees in advance, either specifically or generally, to be bound by the ruling.

Sec. 18.23.070. DEFINITIONS. In this chapter, unless the context otherwise requires,

(1) "administrative staff" means the staff of a hospital or clinic;

(2) "health care" means professional services rendered by a health care provider or an employee of a health care provider, and services furnished by a sanatorium, rest home, nursing home, boarding home or other institution for the hospitalization or care of human beings;

(3) "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.-

72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital;

(4) "professional service" means service rendered by a health care provider of the type he is licensed to render;

(5) "review organization" means a hospital governing body or a committee whose membership is limited to health care providers and administrative staff, except where otherwise provided for by state or federal law, and which is established by a hospital, by a clinic, by one or more state or local associations of health care providers, by an organization of health care providers from a particular area or medical institution, or by a professional standards review organization established under 42 U.S.C., sec. 1320c-1 et seq., to gather and review information relating to the care and treatment of patients for the purposes of

(A) evaluating and improving the quality of health care rendered in the area or medical institution;

(B) reducing morbidity or mortality;

(C) obtaining and disseminating statistics and information relative to the treatment and prevention of diseases, illness and injuries;

(D) developing and publishing guidelines showing the norms of health care in the area or medical institution;

(E) developing and publishing guidelines designed to keep the cost of health care within reasonable bounds;

(F) reviewing the quality or cost of health care services provided to enrollees of health maintenance organizations;

(G) acting as a professional standards review organization under 42 U.S.C., sec. 1320c-1 et seq.;

(H) reviewing, ruling on, or advising on controversies, disputes or questions between

(i) a health insurance carrier or health maintenance organization and one or more of its insured or enrollees;

(ii) a professional licensing board, acting under its powers of discipline or license revocation or suspension, and a health care provider licensed by it, when the matter is referred to a review organization by the professional licensing board;

(iii) a health care provider and his patients concerning diagnosis, treatment or care, or a charge or fee;

(iv) a health care provider and a health insurance carrier or health maintenance organization concerning a charge or fee for health care services provided to an insured or enrollee; or

(v) a health care provider or his patients and the federal or a state or local government, or an agency of the federal or a state or local government;

(I) acting on the recommendation of a credential review committee or a grievance committee.

* Sec. 41. AS 21 is amended by adding a new chapter to read:

CHAPTER 88. HEALTH CARE PROVIDERS INSURANCE.

ARTICLE 1. PURPOSE.

Sec. 21.88.010. PURPOSE OF CHAPTER. It is the purpose of this chapter to provide a means of furnishing health care providers with adequate insurance against liability for medical negligence.

ARTICLE 2. MEDICAL INDEMNITY CORPORATION OF ALASKA.

Sec. 21.88.020. CORPORATION CREATED. There is created the Medical Indemnity Corporation of Alaska which is a public corporation having a legal existence independent of and separate from the state. Obligations issued by the corporation do not constitute a debt, liability or obligation of the state or a pledge of full faith and credit of the state.

Sec. 21.88.030. CORPORATION BOARD OF GOVERNORS. (a) The corporation shall exercise its powers through a board of governors which is appointed by the governor of the state and confirmed by the legislature. Members of the board of governors shall be Alaska residents as follows:

(1) two physicians licensed in the state; one of the physicians shall be engaged in group practice in a clinic of six or more physicians;

(2) an administrator or senior executive officer employed by a hospital licensed in the state;

(3) two professionals from insurance companies authorized in the state;

(4) two persons who are not health care providers or financially interested in the field of health care or representatives of the insurance industry.

(b) The term of office of each governor is three years, except that the governor of the state shall designate two initially appointed governors to serve for one year and two initially appointed governors to serve for two years. Upon the expiration of the term of a governor, the governor of the state shall appoint a successor who shall be from the same class described in (a) of this section as the governor whose term has expired.

(c) Upon a governor's early resignation, death or inability to

serve, the governor of the state shall appoint a successor from the same class defined in (a) of this section as the terminating governor, who shall serve for the unexpired term.

(d) The director or his designee is not a voting member of the board of governors but shall be notified by the board of and have the right to attend and participate in all meetings and proceedings of the board.

(e) Members of the board of governors receive compensation from the corporation of $100 per day when the board meets and necessary travel expenses.

Sec. 21.88.040. CORPORATION PLAN OF OPERATION. (a) Within 30 days after the effective date of this chapter, the board of governors shall prepare and submit to the director for approval a plan of operation which provides for the fair, reasonable and equitable administration of the affairs of the corporation and the discharge of the purposes for which it is created. The plan and any amendments to it become effective upon the director's approval. If the board of governors fails to submit a plan of operation, or if at a subsequent time the board of governors fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate a plan of operation or amendments which are necessary or advisable to carry out the provisions of this chapter. Adoption of the plan is not subject to the Administrative Procedure Act (AS 44.62).

(b) The plan of operation shall

(1) establish the procedures by which all the powers and duties of the corporation specified in sec. 50 of this chapter shall be performed;

(2) establish procedures for handling assets and discharging liabilities of the corporation;

(3) establish regular times and places for meetings of the board of governors;

(4) establish procedures for records to be kept of all financial transactions of the corporation, its agents, and the board of governors;

(5) establish the procedures for awarding contracts to carry out the provisions of this chapter;

(6) establish the procedures for issuing contracts of insurance as provided in sec. 50 of this chapter and for the determination of rates;

(7) contain additional provisions necessary for the execution of the powers and duties of the corporation.

Sec. 21.88.050. POWERS AND DUTIES OF THE CORPORATION. (a) The corporation shall

(1) in the form approved by the director, issue to all physicians and hospitals who pay the premiums for it a contract or contracts indemnifying the physicians and hospitals and their employees who are physicians against loss by reason of liability for professional services on an occurrence basis and agreeing to tender on behalf of the physicians and hospitals and their employees who are physicians a defense in a proceeding brought under AS 09.55.530 - 09.55.560; the limit of liability shall be no less than the minimum liability coverage requirements to be maintained under AS 08.64.215 and AS 18.20.045; the contract shall cover the defense against but need not indemnify a claim for punitive damages; at the option of the physician or hospital and for an additional premium the contract may cover claims against the physician or hospital that arise out of professional services performed by the physician or hospital after December 31, 1974 except that coverage will not be provided for a claim already filed or of which the physician or

hospital had or reasonably should have had notice at the time the retroactive insurance was purchased;

(2) in a form approved by the director and for a premium determined under sec. 80 of this chapter, issue contracts of insurance on an occurrence basis indemnifying chiropractors, dental hygienists, dentists, nurses, dispensing opticians, optometrists, pharmacists, physical therapists, or psychologists and psychological associates, if a finding of unavailability of insurance and impairment of services has been made under AS 08.20.115, AS 08.32.015, AS 08.36.115, AS 08.68.165, AS 08.71.085, AS 08.72.115, AS 08.80.115, AS 08.84.035, or AS 08.86.125; and agreeing to tender on behalf of the person insured under this paragraph a defense in a proceeding under AS 09.55.530 - 09.55.560; the contract shall cover the defense against but need not indemnify a claim for punitive damages;

(3) charge a premium for the protection provided by the contracts issued by the corporation which shall be determined by the board of governors in accordance with sec. 80 of this chapter and subject to the approval of the director;

(4) comply with or be subject to AS 21.06.090; 21.06.120; 21.06.140; 21.06.160; 21.06.250; AS 21.09.180; 21.09.190; 21.09.200; 21.09.250; 21.09.280; AS 21.12.020(b), (c), (d), and (e); and chs. 18, 21, 24, and 36 of this title; and shall be exempt from participation as a member insurer in the Alaska Insurance Guaranty Corporation;

(5) carry out the obligations of the contracts issued by the corporation by defending all covered claims made against insured health care providers and by paying all liabilities which are finally adjudicated against the insured health care provider or which may in the opinion of the corporation reasonably be expected to be finally adjudicated against the health care provider to the extent of the contract

obligation;

(6) provide coverage to physicians and hospitals for liability in excess of the minimum limits required for licensure as a physician or hospital, but limited to $1,000,000 for physicians and $5,000,000 for hospitals, if there is a finding by the director that this coverage is unavailable at a reasonable cost and that this coverage can be made available at a reasonable cost through the corporation; if this paragraph is implemented, then each physician or hospital obtaining excess coverage up to these amounts shall obtain it from the corporation, and the corporation may procure reinsurance for all risks incurred by contracts issued under this paragraph from the private market.

(b) The corporation may

(1) employ or retain persons, individual or corporate, to discharge its obligations and pay reasonable compensation for those services; employees of the corporation are not considered state employees;

(2) recommend that the director hold public hearings for the purpose of commencing operation of the joint underwriting association established under secs. 110 - 180 of this chapter; if the joint underwriting association begins operation, the corporation may purchase reinsurance from the association for any of the liability incurred by contracts issued by the corporation;

(3) provide coverage to physicians and hospitals for other hazards when there is a finding by the director that this coverage is otherwise unavailable by reason of the operation of the corporation;

(4) borrow or advance funds necessary to carry out the purposes of the corporation;

(5) negotiate and become a party to those contracts as are necessary to carry out the purposes of the corporation;

(6) sue or be sued in the name of the corporation;

(7) provide risk management advice and services to hospitals;

(8) negotiate and become a party to contracts for management services for the corporation;

(9) perform all other acts necessary and proper to carry out the duties of the corporation.

Sec. 21.88.060. PREMIUM TAX. The corporation shall pay a premium tax in the amount of one and one-half per cent of the total direct premium income received by the corporation during the year ending on the preceding December 31, after deducting the applicable cancellations, returned premium, the unabsorbed portion of any deposit premiums, all policy dividends, unabsorbed premiums refunded to policyholders, refunds, savings, savings coupons and other similar returns paid or credited to policyholders with respect to their policies. The tax shall be paid to the director annually before April 1 of each year.

Sec. 21.88.070. STATISTICS. The corporation shall collect, maintain and report information concerning claims against health care providers. The information shall be on forms prescribed by the director, and shall be sufficient to enable a proper determination of losses for rate making and to identify causes and sources of loss for loss control. At least annually the corporation shall report to the director the number and amount of claims filed, reserved, paid, settled and adjudicated during the year, the premiums paid to and the expenses incurred by the corporation during the year. This report shall be available to the public. The director may require that supplemental reports include the names of insured health care providers and the claimants; however, no reports which become available to the public may include the names of health care providers or claimants or information that will permit by inference the identity of specific health care

providers or claimants. All statistics shall be made available to the appropriate licensing board or agency.

Sec. 21.88.080. RATES. The rates and rating plans used by the corporation for the policies issued shall be determined by license category of health care providers in accordance with all of the following:

(1) rates for physicians shall be set as a function of the physician's medical revenue;

(2) rates for hospitals shall be set as a function of the number of permanent beds in the hospital;

(3) a minimum rate may be set for each category of health care provider or discipline or classification within the license category;

(4) rates may not be excessive; rates are excessive if, after a period of time and with respect to an amount of gross premium which are actuarially credible, the premiums exceed losses incurred by the corporation, including losses paid, reserves for claims reported and unpaid, reserves for claims incurred during the policy period and not reported, provided that reserves for claims incurred during the policy period and reasonably expected to be reported after three years after the incident may be included on a different basis due to the additional financial flexibility provided by the corporation, and reasonable expenses for the operation of the corporation;

(5) rates shall not be inadequate; rates are inadequate if, based on available actuarial data, the premiums to be paid by the health care providers are or may reasonably be expected to be insufficient to pay for losses incurred by the corporation, including claims paid, reserves for claims reported and unpaid, reserves for claims incurred during the policy period and not reported, provided that reserves for claims incurred during the policy period and reasonably

expected to be reported after three years after the incident may be included on a different basis due to the additional financial flexibility provided by the corporation, and reasonable expenses for the operation of the corporation;

(6) rates may not be unfairly discriminatory;

(7) rates shall be adjusted annually;

(8) rates for any policy year shall be calculated to include the adjustment for actual experience of the corporation as developed for the preceding four policy years;

(9) in considering losses to be incurred, changes in the law, national, regional or local trends in medical negligence awards, and other relevant factors may be considered;

(10) income from the investment of reserves shall be considered;

(11) individual risk underwriting factors shall be considered;

(12) disciplines and classifications within the license categories of health care providers shall be considered;

(13) amounts sufficient for repayment of loan obligations shall be considered.

Sec. 21.88.090. PAYMENT OF PREMIUMS; CANCELLATION OF INSURANCE. The corporation may provide for installment payment of premiums in which event each installment is due by the date specified. The corporation may cancel any of its policies in the event of nonpayment of any premium or installment on a premium, or other charge, by mailing or delivering to the insured at the address shown on the policy and to the agency of the state issuing the insured's license written notice of cancellation. Cancellation is not effective until 30 days after the date notice is posted by the corporation.

ARTICLE 3. JOINT UNDERWRITING ASSOCIATION.

Sec. 21.88.110. ASSOCIATION CREATED. (a) The Health Care Providers Joint Underwriting Association is created as an association having a legal existence independent of and separate from the state and consisting of all licensed (1) health care service corporations as defined in AS 21.87.330; (2) disability insurers as defined in AS 21.12.-050; (3) property insurers as defined in AS 21.12.060; and (4) casualty insurers as defined in AS 21.12.070. Obligations issued by the association do not constitute a debt, liability or obligation of the state or a pledge of full faith and credit of the state.

(b) Every insurer described in (a) of this section is a member of the association and shall remain a member as a condition of its authority to continue to transact that kind of business in the state.

(c) The association shall commence operation if the director finds, after public hearing, that a market for reinsurance for any portion of its insurance coverage is needed by the corporation. After the association has commenced operation, if the director determines, after public hearing, that a market for reinsurance is no longer needed by the corporation, the association shall cease its underwriting operations.

Sec. 21.88.120. PURPOSE. The purpose of the association is to provide a market for medical malpractice reinsurance to the corporation on a self-supporting basis without subsidy from association members.

Sec. 21.88.130. ASSOCIATION BOARD OF DIRECTORS; TERM; COMPENSATION. (a) The association shall be governed by a board of directors appointed by the governor of the state and consisting of two representatives of domestic casualty and property insurers, one representative of admitted disability insurers, one representative of health care service corporations, one representative of foreign casualty and property insurers, and two persons from the public.

(b) Members of the board of directors serve three-year terms.

(c) Members of the board of directors receive compensation from the association of $100 per day when the board meets and necessary travel expenses.

Sec. 21.88.140. ASSOCIATION PLAN OF OPERATION. (a) Within 30 days after the association commences operation the board of directors shall prepare and submit to the director for his approval a plan of operation which provides for the fair, reasonable and equitable administration of the affairs of the association and the discharge of the purposes for which it is created. The plan and any amendments to it become effective upon the director's approval. If the board of directors has failed to submit a plan of operation, or if at any subsequent time the board of directors fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate a plan of operation or amendments which are necessary or advisable to carry out the provisions of this chapter. Adoption of the plan is not subject to the Administrative Procedure Act (AS 44.62).

(b) The plan of operation shall

(1) establish the procedures for carrying out the powers and duties of the association specified in sec. 150 of this chapter;

(2) establish procedures for handling assets and discharging liabilities of the association;

(3) establish regular times and places for meetings of the board of directors;

(4) establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(5) establish the procedures for awarding contracts to indemnify or defend or to provide other services and to compensate the indemnitors or vendors;

(6) establish the procedures for issuing contracts of insurance as provided in sec. 150 of this chapter and for the determination of rates;

(7) contain additional provisions necessary for the execution of the powers and duties of the association.

Sec. 21.88.150. POWERS AND DUTIES OF THE ASSOCIATION. (a) The association shall

(1) provide reinsurance to the corporation covering contracts issued by the corporation for that portion of the liability incurred by the corporation it chooses to reinsure through the association, indemnifying physicians and hospitals, their employees who are physicians, and other persons insured by the corporation against loss by reason of liability for professional services and agreeing to tender on behalf of the insureds a defense in an action brought under AS 09.55.530 - 09.55.-560;

(2) charge a premium for the protection provided by the reinsurance issued under (a)(1) of this section which shall be determined by the board of directors in accordance with secs. 80 and 160 of this chapter and are subject to the approval of the director;

(3) comply with or be subject to AS 21.06.090; 21.06.120; 21.06.140; 21.06.160; 21.06.250; AS 21.09.180; 21.09.200; 21.09.250; 21.09.280; AS 21.12.020(b), (c), (d), and (e); and chs. 18, 21, 24, and 36 of this title; and shall be exempt from participation as a member insurer in the Alaska Insurance Guaranty Association;

(4) carry out the obligations of the contracts issued under (a)(1) of this section by defending all covered claims made against the insureds and paying all liabilities which are finally adjudicated against the insureds or which may in the opinion of the association reasonably be expected to be finally adjudicated against the insured

to the extent of the contract obligation.

(b) The association may

(1) employ or retain persons, individual or corporate, to discharge its obligations and pay reasonable compensation for those services; employees of the association are not considered state employees;

(2) borrow or advance funds necessary to carry out the purposes of the association;

(3) negotiate and become a party to those contracts which are necessary to carry out the purposes of the association;

(4) sue or be sued in the name of the association;

(5) cede or assume reinsurance;

(6) perform all other acts necessary and proper to carry out the duties of the association.

Sec. 21.88.160. RATES AND RATE ADJUSTMENT. (a) The rates and rating plans shall be determined as provided in sec. 80 of this chapter, except that allowance may not be made for income from investment of member-contributed funds; and provided that reserves for claims incurred during the policy period and reasonably expected to be reported after three years after the incident may be included on a different basis due to the additional financial flexibility provided by the association.

(b) If in any year an assessment is made under sec. 170 of this chapter, rates for the next period shall be increased from the rate determined under (a) of this section by an amount sufficient to reimburse all members the amounts assessed. No assessment may be reimbursed to members without prior approval of the director and no interest accrues in favor of members on amounts assessed.

(c) If after establishing required reserves and repaying all assessments to members there is an excess amount in reserve, the excess

premium shall be refunded to the corporation for reimbursement to the insureds.

Sec. 21.88.170. ASSESSMENT. If sufficient funds are not available for the sound financial operation of the association, all members shall contribute to the financial requirements of the association by paying to the association an assessment to be determined by the board of directors of the association, subject to the approval of the director; assessments shall be prorated among all members in proportion to their direct written premiums or revenues in the state in the insurance lines the writing of which require membership in the association, in the two years ending on the preceding December 31, after deducting the applicable cancellations, returned premium, the unabsorbed portion of any deposit premium, all policy dividends, unabsorbed premiums refunded to policyholders, refunds, savings, savings coupons and other similar returns paid or credited to policyholders with respect to their policies. If any member is prohibited by the law of its state of domicile from paying an assessment to the association, then in lieu of the assessment the member shall pay a tax to the director, in the same amount as the assessment as an obligation in addition to taxes required under AS 21.09.210 and notwithstanding the provisions of AS 21.09.210(e). An amount equal to taxes received under this section may be appropriated to the association.

Sec. 21.88.180. REPORTS. At least annually the association shall report to the director concerning its affairs. The report shall be in the form prescribed by the director.

ARTICLE 4. LOAN FUND.

Sec. 21.88.210. FUND ESTABLISHED. (a) There is in the Department of Commerce and Economic Development a medical malpractice liability revolving loan fund to be administered by the director of insurance.

(b) An initial Loan may be made from the fund to the corporation

upon certification by the director that a loan is necessary ~~for the corporation or association to spread costs out over time because of fluctuations~~ for the foregoing purposes, to capitalize the corporation in loss experience. If a loan is made to the corporation from the fund, the corporation shall issue a note to the fund as evidence of the loan.

~~(c) Loans from the fund shall be repaid within five years at an annual interest rate of six per cent.~~

(d) The director may sell at par value to the Department of Revenue the notes, security instruments and pledge agreements held by the Department of Commerce and Economic Development as security for loans made under this section. The Department of Revenue shall purchase all the notes offered until the current principal amount of the notes purchased and held by the Department of Revenue equals $5,000,000.

ARTICLE 5. GENERAL PROVISIONS.

Sec. 21.88.900. DEFINITIONS. In this chapter

(1) "association" means the Health Care Providers Joint Underwriting Association;

(2) "corporation" means the Medical Indemnity Corporation of Alaska;

(3) "governor" means a member of the board of governors of the Medical Indemnity Corporation of Alaska;

(4) "health care provider" means a person or institution insured under this chapter;

(5) "physician" means a person licensed under AS 08.64;

(6) "hospital" means an institution licensed under AS 18.20;

(7) "chiropractor" means a person licensed under AS 08.20;

(8) "dental hygienist" means a person licensed under AS 08.32;

(9) "dentist" means a person licensed under AS 08.36;

(10) "dispensing optician" means a person licensed under

AS 08.71;

(11) "optometrist" means a person licensed under AS 08.72;

(12) "physical therapist" means a person licensed under AS 08.80;

(13) "pharmacist" means a person licensed under AS 08.84;

(14) "psychologist" and "psychological associate" means a person licensed under AS 08.86.

* Sec. 42. AS 21.18.090 is amended by adding new paragraphs to read:

(5) reserves for the Medical Indemnity Corporation of Alaska are to include only reserves for claims reported and unpaid and reserves for claims incurred but not reported but which may reasonably be expected to be reported within three years after the date of occurrence;

(6) reserves for the Health Care Providers Joint Underwriting Association are to include claims reported and unpaid; reserves for claims incurred but not reported, but those which may reasonably be expected to be reported beyond three years after the date of occurrence may be included on a different basis due to the additional financial flexibility of the association.

* Sec. 43. AS 21.80.180(5) is amended to read:

(5) "insolvent insurer" means an insurer

(A) authorized to transact insurance in this state, except the Medical Indemnity Corporation of Alaska and the Health Care Providers Joint Underwriting Association established under ch. 88 of this title, either at the time the policy was issued or when the insured event occurred, and

(B) determined to be insolvent by a court of competent jurisdiction;

* Sec. 44. AS 21.80.180(6) is amended to read:

(6) "member insurer" means a person, except the Medical

Indemnity Corporation of Alaska and the Health Care Providers Joint Underwriting Association established under ch. 88 of this title, who

(A) writes any kind of insurance to which this chapter applies under sec. 20 of this chapter including the exchange of reciprocal or inter-insurance contracts, and

(B) is licensed to transact insurance in this state;

* Sec. 45. AS 08.02 is amended by adding a new section to read:

Sec. 08.02.020. LIMITATION OF LIABILITY FOR MEMBERS OF LICENSING BOARDS. No person is liable for damages or other relief in an action by reason of his performance of a duty, function, or activity as a member of a licensing board or by reason of a recommendation or action of the board when the person acts in the reasonable belief that his action or recommendation is warranted by facts known to him or to the board after reasonable efforts to ascertain the facts upon which the action or recommendation is made.

* Sec. 46. AS 09.55.536, enacted in sec. 33 of this Act, has the effect of changing the Alaska Supreme Court's Rules of Civil Procedure by requiring the submission of medical malpractice actions against health care providers to expert advisory panels before discovery unless the court decides an expert advisory opinion is not necessary in the case.

* Sec. 47. AS 08.64.365 and AS 08.68.040 are repealed.

* Sec. 48. Secs. 33 - 38 of this Act apply to all causes of action for medical malpractice which have not been filed in a court of this state ~~prior to~~ before the effective date of this Act.

* Sec. 49. Secs. 1 - 32 and secs. 39 - 47 take effect 30 days after the effective date of this Act.

* Sec. 50. This Act takes effect immediately in accordance with AS 01.-10.070(c).

Note: the severability clause will be added

proofed
4/22
4/26

Original Sponsor: Rules Committee by request of the Governor

IN THE HOUSE BY THE FREE CONFERENCE COMMITTEE

FREE CONFERENCE CS FOR SENATE CS FOR CS FOR HOUSE BILL NO. 574

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to health care; changing the Alaska Supreme Court's Rules of Civil Procedure; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 08.01.050 is amended by adding a new paragraph to read:

(19) provide investigative services to the boards established under chs. 20, 32, 36, 64, 68, 71, 72, 80, 84, and 86 of this title, for the purpose of assisting those boards in matters of professional discipline.

* Sec. 2. AS 08.20.010 is amended to read:

Sec. 08.20.010. CREATION AND MEMBERSHIP OF BOARD OF CHIROPRACTIC EXAMINERS. There is created the Board of Chiropractic Examiners consisting of <u>five</u> [THREE] members appointed by the governor.

* Sec. 3. AS 08.20.020 is amended to read:

Sec. 08.20.020. MEMBERS OF BOARD. <u>Three members</u> [EACH MEMBER] of the board shall be [A] licensed chiropractic <u>physicians who</u> [PHYSICIAN AND SHALL] have practiced chiropractic in this state not less than two years. <u>Two members of the board shall be persons with no direct financial interest in the health care industry.</u> Each member serves without pay but is entitled to per diem and travel expenses allowed by law.

* Sec. 4. AS 08.20.030 is repealed and re-enacted to read:

Sec. 08.20.030. MEMBERS TERMS, VACANCIES. Members serve for staggered terms of three years. The terms of the public members of the board may not expire at the same time. Vacancies on the board shall be

unclear

filled for the unexpired term.

* Sec. 5. AS 08.20 is amended by adding a new section to read:

Sec. 08.20.115. MALPRACTICE INSURANCE. If medical malpractice insurance for chiropractors becomes unavailable on the voluntary market and the director of insurance finds, after public hearing, that the unavailability is impairing the delivery of chiropractic services to the public, the director of insurance may require all persons licensed under this chapter to carry malpractice insurance and to purchase their insurance from the Medical Indemnity Corporation of Alaska established under AS 21.88. Compliance with the requirements of this section is a condition of licensure under this chapter. This requirement is satisfied if the licensee's employer maintains insurance for him from the Medical Indemnity Corporation of Alaska.

* Sec. 6. AS 08.20 is amended by adding a new section to read:

Sec. 08.20.175. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 170 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education or health the authority to practice chiropractic should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 7. AS 08.32 is amended by adding new sections to read:

Sec. 08.32.015. MALPRACTICE INSURANCE. If medical malpractice insurance for dental hygienists becomes unavailable on the voluntary market and the director of insurance finds, after public hearing, that the unavailability is impairing the delivery of dental hygiene services

to the public, the director of insurance may require all persons licensed under this chapter to carry malpractice insurance and to purchase their insurance from the Medical Indemnity Corporation of Alaska established under AS 21.88. Compliance with the requirements of this section is a condition of licensure under this chapter. The provisions of this section are satisfied if the licensee's employer maintains insurance for him from the Medical Indemnity Corporation of Alaska.

Sec. 08.32.165. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 160 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education or health the authority to practice dental hygiene should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 8. AS 08.36.010 is amended to read:

Sec. 08.36.010. CREATION AND MEMBERSHIP OF BOARD. There is created the Board of Dental Examiners, referred to in this chapter as the board, consisting of <u>seven</u> [FIVE] members. <u>Five members</u> [EACH MEMBER] shall be [A CITIZEN OF THE UNITED STATES AND A] qualified resident <u>dentists</u> who <u>have</u> [HAS] been engaged in the practice of dentistry in the state for five years immediately preceding [HIS] appointment<u>, and two members shall be persons with no direct financial interest in the health care industry</u>.

* Sec. 9. AS 08.36.020 is amended to read:

Sec. 08.36.020. APPOINTMENT AND TERM OF SERVICE OF MEMBERS. Members of the board are appointed by the governor, subject to confirmation by the legislature in joint session [ASSEMBLED]. Each

board member serves for a term of five years, and until his successor is appointed and qualified except that the terms of the public members on the board shall be staggered so that they do not expire at the same time. The term begins on February 1. An appointment to a vacancy is for the unexpired term. [APPOINTMENTS SHALL BE MADE FROM A LIST OF NAMES RECOMMENDED BY THE ALASKA DENTAL SOCIETY. THE LIST SHALL BE SUPPLIED AT LEAST 30 DAYS BEFORE THE BEGINNING OF A TERM AND NOT MORE THAN 60 DAYS AFTER THE OCCURRENCE OF A VACANCY. THE LIST SHALL CONTAIN AT LEAST TWO RECOMMENDED NAMES FOR EACH APPOINTMENT. THE GOVERNOR SHALL MAKE THE APPOINTMENT WITHIN 30 DAYS AFTER RECEIVING THE LIST.]

* Sec. 10. AS 08.36 is amended by adding new sections to read:

Sec. 08.36.115. MALPRACTICE INSURANCE. If medical malpractice insurance for dentists becomes unavailable on the voluntary market and the director of insurance finds, after public hearing, that the unavailability is impairing the delivery of dental services to the public, the director of insurance may require all persons licensed under this chapter to carry malpractice insurance and to purchase their insurance from the Medical Indemnity Corporation of Alaska established under AS 21.88. Compliance with the requirements of this section is a condition of licensure under this chapter. The requirements of this section are satisfied if the licensee's employer maintains insurance for him from the Medical Indemnity Corporation of Alaska.

Sec. 08.36.325. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 320 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health, the authority to practice dentistry should be limited or conditioned or the practitioner disciplined, the board may censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 11. AS 08.64.010 is amended to read:

Sec. 08.64.010. CREATION AND MEMBERSHIP OF STATE MEDICAL BOARD. The governor shall appoint a board of medical examiners, to be known as the State Medical Board, consisting of five licensed physicians, residing in as many separate Alaska judicial districts as possible, and two persons with no direct financial interest in the health care industry. [EACH MEMBER SHALL BE CHOSEN FROM A PANEL OF THREE, FOR EACH VACANCY, SUBMITTED TO THE GOVERNOR BY THE ALASKA STATE MEDICAL ASSOCIATION.]

* Sec. 12. AS 08.64.020 is amended to read:

Sec. 08.64.020. STATE MEDICAL BOARD TERM OF OFFICE. Members shall be appointed for a term of four years, subject to confirmation by a majority of the members of the legislature in joint session, and shall hold office until their successors are appointed and qualified. The terms of the public members of the board shall be staggered so that they do not expire at the same time.

* Sec. 13. AS 08.64.090 is amended to read:

Sec. 08.64.090. QUORUM. Four [THREE] members of the board constitute a quorum for the transaction of all business properly before the board.

* Sec. 14. AS 08.64 is amended by adding new sections to read:

Sec. 08.64.215. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person shall maintain insurance issued by the Medical Indemnity Corporation of Alaska against liability to patients for medical malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him

from the Medical Indemnity Corporation of Alaska in the required amounts.

(b) The director of insurance or his designee shall waive the requirement in (a) of this section for a person if that person furnishes satisfactory evidence of his having other insurance providing coverage in amounts not less than those specified in (a) of this section. No waiver granted under this subsection may extend beyond the normal expiration date of the person's insurance policy or January 1, 1977, whichever occurs first.

Sec. 08.64.312. CONTINUING EDUCATION REQUIREMENTS. (a) The board shall promote a high degree of competence in the practice of medicine by requiring every physician licensed in the state to fulfill continuing education requirements.

(b) Before a license may be renewed the licensee shall submit evidence to the board that continuing education requirements prescribed by regulations adopted by the board have been met.

(c) The board may exempt a physician from the requirements of (b) of this section upon an application by him giving evidence satisfactory to the board that he is unable to comply with the requirements because of extenuating circumstances. However, no person may be exempted from more than 15 hours of continuing education in a five-year period.

Sec. 08.64.325. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 330 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 15. AS 08.68.010 is amended to read:

Sec. 08.68.010. CREATION AND MEMBERSHIP OF BOARD OF NURSING. There is created a Board of Nursing, consisting of seven [FIVE] members appointed by the governor. One member shall be currently involved in institutional nursing service, one member in community or public health nursing and two members in basic or continuing nursing education, [AND] one nurse at large, and two persons who have no direct financial interest in the health care industry.

* Sec. 16. AS 08.68.020 is repealed and re-enacted to read:

Sec. 08.68.020. TERM OF OFFICE. Members serve staggered terms of five years and until their successors are appointed. The terms of the public members on the board shall be set so that they do not expire at the same time. Vacancies on the board shall be filled for the unexpired term.

* Sec. 17. AS 08.68.060 is amended to read:

Sec. 08.68.060. QUALIFICATIONS OF BOARD MEMBERS. The five members [EACH MEMBER] of the board who are nurses shall be [A CITIZEN OF THE UNITED STATES, A RESIDENT OF THE STATE, AND A] licensed professional nurses [NURSE] in the state, and [MEMBERS] shall have been actively engaged in nursing for not less than four years before appointment, two years of which were within the five years preceding appointment.

* Sec. 18. AS 08.68 is amended by adding new sections to read:

Sec. 08.68.165. MALPRACTICE INSURANCE. If medical malpractice insurance for nurses becomes unavailable on the voluntary market and the director of insurance finds, after public hearing, that the unavailability is impairing the delivery of nursing services to the public, the director of insurance may require all persons licensed under this chapter to carry malpractice insurance and to purchase their insurance from the Medical Indemnity Corporation of Alaska established under AS 21.88.

Compliance with the requirements of this section is a condition of licensure under this chapter. The requirements of this section are satisfied if the licensee's employer maintains insurance for him from the Medical Indemnity Corporation of Alaska.

Sec. 08.68.275. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 270 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice nursing should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 19. AS 08.71.020 is amended to read:

Sec. 08.71.020. MEMBERSHIP OF BOARD; SOURCE OF APPOINTMENTS; TERM OF OFFICE. The board consists of <u>seven</u> [FIVE] persons appointed by the governor. <u>Members serve staggered terms of three years. The terms of the public members of the board shall be set so that they do not expire at the same time.</u> [THE GOVERNOR SHALL APPOINT BOARD MEMBERS FROM A LIST OF QUALIFIED OPTICIANS PREPARED BY THE ASSOCIATION OF OPTICIANS IN THE STATE AND SUBMITTED AT LEAST 30 DAYS BEFORE JULY 1, 1973, AT LEAST 30 DAYS BEFORE THE EXPIRATION OF A TERM AND NOT MORE THAN 60 DAYS AFTER A VACANCY OCCURS IN AN UNEXPIRED TERM. THE LIST SHALL CONTAIN NOT LESS THAN TWO RECOMMENDED CANDIDATES FOR EACH APPOINTMENT. THE GOVERNOR SHALL MAKE APPOINTMENTS WITHIN 30 DAYS AFTER RECEIVING THE LIST. THE TERM OF OFFICE OF EACH MEMBER IS THREE YEARS. HOWEVER, OF THE FIRST MEMBERS OF THE BOARD, ONE SHALL BE APPOINTED FOR A ONE-YEAR TERM, TWO FOR TWO-YEAR TERMS, AND TWO FOR THREE-YEAR TERMS.] Vacancies on the board shall be filled for the unexpired term [IN THE SAME MANNER AS

ORIGINAL APPOINTMENT].

* Sec. 20. AS 08.71.030 is amended to read:

Sec. 08.71.030. QUALIFICATIONS OF BOARD MEMBERS. Five [A] board members [MEMBER] shall be [A] licensed, practicing dispensing opticians [OPTICIAN] residing in the state. Two shall be persons with no direct financial interest in the health care industry.

* Sec. 21. AS 08.71 is amended by adding new sections to read:

Sec. 08.71.085. MALPRACTICE INSURANCE. If medical malpractice insurance for opticians becomes unavailable on the voluntary market and the director of insurance finds, after public hearing, that the unavailability is impairing the delivery of optician services to the public, the director of insurance may require all persons licensed under this chapter to carry malpractice insurance and to purchase their insurance from the Medical Indemnity Corporation of Alaska established under AS 21.88. Compliance with the requirements of this section is a condition of licensure under this chapter. The requirements of this section are satisfied if the licensee's employer maintains insurance for him from the Medical Indemnity Corporation of Alaska.

Sec. 08.71.175. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 170 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice as a dispensing optician under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 22. AS 08.72.020 is amended to read:

Sec. 08.72.020. MEMBERSHIP OF BOARD AND TERMS OF OFFICE. The board consists of <u>five</u> [THREE] persons, appointed by the governor. <u>Members serve staggered terms of three years. The terms of the public members of the board shall be set so that they do not expire at the same time.</u> [THE TERM OF EACH MEMBER IS THREE YEARS. ONE MEMBER ONLY IS APPOINTED EACH YEAR, EXCEPT WHEN VACANCIES FOR UNEXPIRED TERMS ARE FILLED.]

* Sec. 23. AS 08.72.040 is repealed and re-enacted to read:

Sec. 08.72.040. QUALIFICATIONS. Three board members shall be licensed, practicing optometrists who have been residents for at least three years. Two shall be persons who have no direct financial interest in the health care industry.

* Sec. 24. AS 08.72 is amended by adding new sections to read:

Sec. 08.72.115. MALPRACTICE INSURANCE. If medical malpractice insurance for optometrists becomes unavailable on the voluntary market and the director of insurance finds, after public hearing, that the unavailability is impairing the delivery of optometrist services to the public, the director of insurance may require all persons licensed under this chapter to carry malpractice insurance and to purchase their insurance from the Medical Indemnity Corporation of Alaska established under AS 21.88. Compliance with this section is a condition of licensure under this chapter. The requirements of this section are satisfied if the licensee's employer maintains insurance for him from the Medical Indemnity Corporation of Alaska.

Sec. 08.72.255. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under secs. 240 and 250 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice optometry under this chapter should be limited or conditioned or the practitioner

disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 25. AS 08.80.010 is amended to read:

Sec. 08.80.010. CREATION AND MEMBERSHIP OF BOARD OF PHARMACY. There is created the Board of Pharmacy, composed of seven [FIVE] members five [EACH] of whom shall be pharmacists [A PHARMACIST] licensed in the state who have [HAS] been actively engaged in the practice of pharmacy in the state for a period of three years immediately preceding their [HIS] appointment. Two shall be persons with no direct financial interest in the health care industry. Whenever possible, the board shall include at least one member from each judicial district.

* Sec. 26. AS 08.80.020 is amended to read:

Sec. 08.80.020. TERM OF OFFICE. Members of the board are appointed by the governor, and confirmed by the legislature in joint session, for overlapping terms of five years, or until their successors are appointed and qualified. The terms of the public members shall be staggered so that they do not expire at the same time. An appointment to fill a vacancy is for the unexpired term. The term of office begins on April 1 of each year.

* Sec. 27. AS 08.80.070 is amended to read:

Sec. 08.80.070. QUORUM. Four [THREE] members constitute a quorum for the transaction of business. However, when the board meets for the purpose of examining applications for registration, three [TWO] members of the board constitute a quorum.

* Sec. 28. AS 08.80 is amended by adding new sections to read:

Sec. 08.80.115. MALPRACTICE INSURANCE. If medical malpractice

insurance for pharmacists becomes unavailable on the voluntary market and the director of insurance finds, after public hearing, that the unavailability is impairing the delivery of pharmacist services to the public, the director of insurance may require all persons licensed under this chapter to carry malpractice insurance and to purchase their insurance from the Medical Indemnity Corporation of Alaska established under AS 21.88. Compliance with the requirements of this section is a condition of licensure under this chapter. The requirements of this section are satisfied if the licensee's employer maintains insurance for him from the Medical Indemnity Corporation of Alaska.

Sec. 08.80.265. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 260 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice pharmacy under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 29. AS 08.84 is amended by adding new sections to read:

Sec. 08.84.035. MALPRACTICE INSURANCE. If medical malpractice insurance for physical therapists becomes unavailable on the voluntary market and the director of insurance finds, after public hearing, that the unavailability is impairing the delivery of physical therapist services to the public, the director of insurance may require all persons licensed under this chapter to carry malpractice insurance and to purchase their insurance from the Medical Indemnity Corporation of Alaska established under AS 21.88. Compliance with this section is a condition

of licensure under this chapter. The requirements of this section are satisfied if the licensee's employer maintains insurance for him from the Medical Indemnity Corporation of Alaska.

Sec. 08.84.185. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 180 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education or health the authority to practice physical therapy should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 30. AS 08.86.010 is amended to read:

Sec. 08.86.010. CREATION AND MEMBERSHIP OF BOARD. There is created a Board of Psychologist and Psychological Associate Examiners. It consists of three licensed psychologists, and two persons who have no direct financial interest in the health care industry.

* Sec. 31. AS 08.86.020 is amended to read:

Sec. 08.86.020. APPOINTMENT AND TERM OF OFFICE. Members of the board are appointed by the governor and confirmed by the legislature for staggered terms of three years. The terms of the public members shall be set so that they do not expire at the same time. A member serves at the pleasure of the governor.

* Sec. 32. AS 08.86 is amended by adding new sections to read:

Sec. 08.86.125. MALPRACTICE INSURANCE. If medical malpractice insurance for psychologists or psychological associates becomes unavailable on the voluntary market and the director of insurance finds, after public hearing, that the unavailability is impairing the delivery of psychologist or psychological associate services to the public, the

director of insurance may require all persons licensed under this chapte to carry malpractice insurance and to purchase their insurance from the Medical Indemnity Corporation of Alaska established under AS 21.88. Compliance with this section is a condition of licensure as a psychologi or psychological associate under this chapter. The requirements of this section are satisfied if a licensee's employer maintains insurance for him from the Medical Indemnity Corporation of Alaska.

Sec. 08.86.220. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) Upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice psychology or as a phsychological associate under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by time, specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 33. AS 09.55 is amended by adding new sections to read:

Sec. 09.55.535. VOLUNTARY ARBITRATION. (a) A patient and any health care provider may execute an agreement to submit to arbitration any dispute, controversy, or issue arising out of care or treatment by the health care provider during the period that the agreement is in force or that has already arisen between the parties.

(b) An agreement to arbitrate executed before care or treatment is provided shall clearly provide in bold print on the face of the agreement that execution of the agreement by the patient is not a prerequisite to receiving care or treatment. If this subsection is not complied with by the health care provider, the agreement to arbitrate is void. The form to be used shall be approved in advance by the attorney general of the state to assure it fairly informs both parties to the agreement

and properly protects their interests.

(c) The agreement shall provide that the person receiving health care may revoke the agreement within 60 days after execution by notifying the health care provider in writing. A health care provider may not revoke the agreement after its execution.

(d) Each admission to a hospital shall be treated as separate and distinct for the purposes of an agreement to arbitrate, but a person receiving outpatient care from a hospital or clinic or a member of a health maintenance organization may execute an agreement with the hospital which provides for continuation of the agreement for a continuing program of treatment or during continued membership.

(e) Upon the filing of a malpractice claim which is subject to an agreement to arbitrate, the claim shall be submitted to an arbitration board. The arbitration board shall consist of three arbitrators: one arbitrator designated by the claimant or claimants, one arbitrator designated by the health care provider or providers against whom the claim is made, and a third arbitrator designated by mutual agreement who shall serve as chairperson of the board. If the parties cannot agree on the third person, the court will provide a choice of three or more persons who might serve as chairperson of the arbitration board, which shall be from a list of qualified arbitrators furnished by the attorney general. Claimant or claimants together and health care provider or providers together may each strike one or more names, so after each side has done so at least one name remains, providing a basis for the final selection by the court.

(f) The attorney general shall prepare a list of persons consisting of lawyers or other persons qualified to serve as chairperson of an arbitration board. They shall be selected on basis of their technical expertise, judicial temperament, and capability of impartially acting on malpractice claims. The attorney general shall submit a list of at

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least three names whenever requested to do so by the court along with detailed biographical information on each person listed.

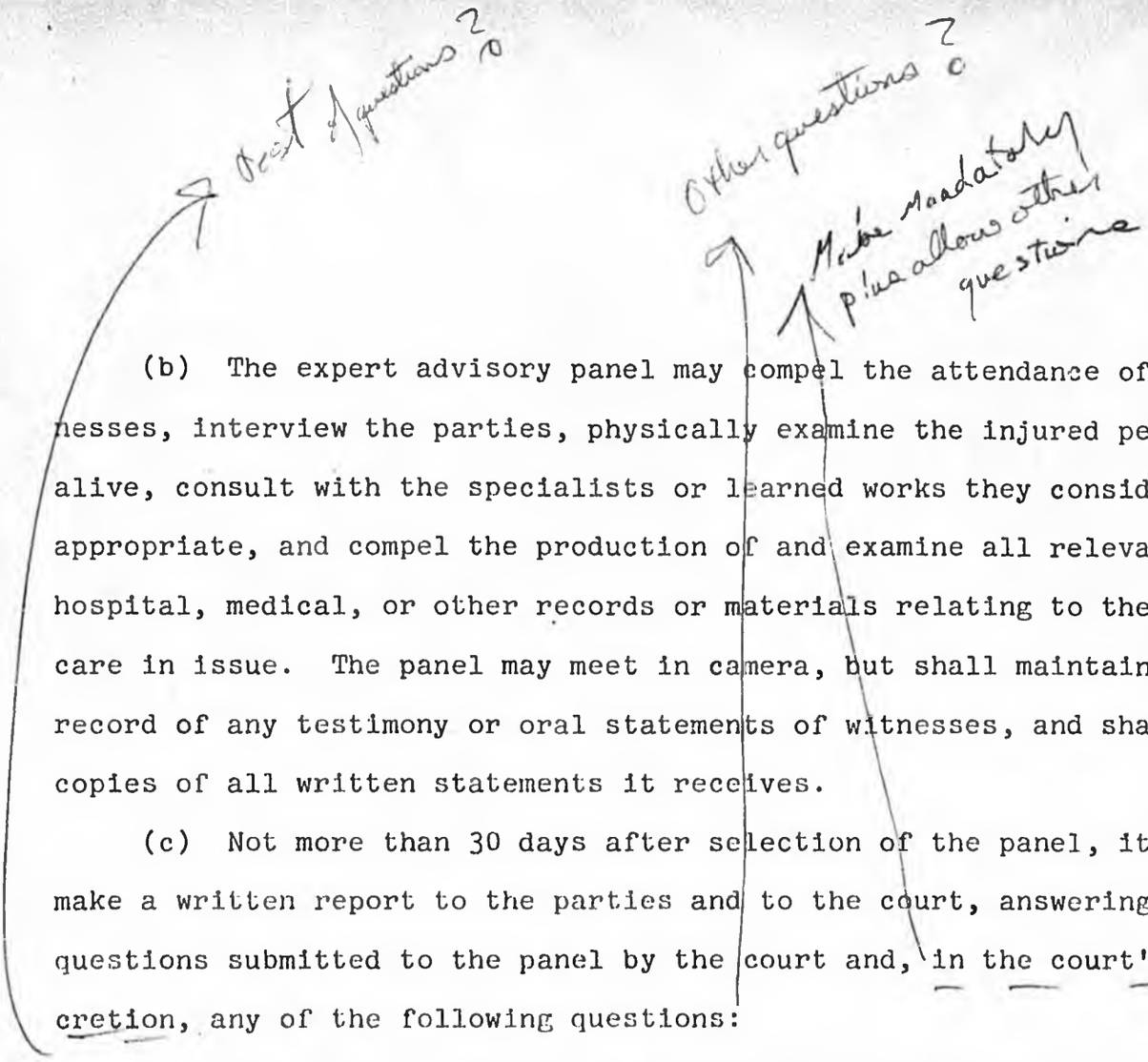
(g) Each member of the arbitration board shall receive reasonable compensation to be paid by the court based on the extent and duration of services rendered. The court shall pay the costs of expert witnesses called by the board and the costs of expert witnesses called by the parties to the arbitration up to a maximum of three witnesses for each side and $150 per day for each expert witness.

(h) The arbitration board may appoint an expert advisory panel, with the powers of the expert advisory panel under sec. 536 of this chapter, to advise the board on the medical facts of the case.

(i) The court shall specify the shortest practical deadline for completion of the work of the arbitration board, taking into account all the circumstances and the nature of the case.

(j) The provisions of the Uniform Arbitration Act, AS 09.43.010 - 09.43.180, apply to arbitrations under this section if they do not conflict with the provisions of this section; arbitrations under this section shall be conducted in accordance with procedures established by any rules of court which may be adopted and according to provisions of secs. 540 - 548 and 554 - 560 of this chapter, and AS 09.65.090 - 09.65.100.

Sec. 09.55.536. EXPERT ADVISORY PANEL. (a) In any action for damages due to personal injury or death based upon the provision of professional services by a health care provider when the parties have not ~~yet~~ agreed to arbitration of the claim under sec. 535 of this chapter, the court shall appoint a three-person expert advisory panel unless the [court decides] that an expert advisory opinion is not necessary for a decision in the case. When the action is filed the court shall, by order, determine the professions or specialties to be represented on the expert advisory panel, giving the parties the opportunity to object or make suggestions.



(b) The expert advisory panel may compel the attendance of witnesses, interview the parties, physically examine the injured person if alive, consult with the specialists or learned works they consider appropriate, and compel the production of and examine all relevant hospital, medical, or other records or materials relating to the health care in issue. The panel may meet in camera, but shall maintain a record of any testimony or oral statements of witnesses, and shall keep copies of all written statements it receives.

(c) Not more than 30 days after selection of the panel, it shall make a written report to the parties and to the court, answering the questions submitted to the panel by the court and, in the court's discretion, any of the following questions:

(1) Was the care which is the subject of the litigation appropriate to the complaint or condition for which the plaintiff sought or was brought to medical care?

(2) Was the care administered in accordance with appropriate medical standards?

(3) Did an injury arise from the medical care?

(4) What is the nature and the extent of the medical injury?

(5) If a medical injury had not occurred, how would the plaintiff's condition differ from the plaintiff's present condition?

(d) In any case in which the answer to one or more of the questions submitted to the panel depends upon the resolution of factual questions which are not the proper subject of expert opinion, the report shall so state and may answer questions based upon hypothetical facts that are fully set out in the opinion. The report shall include copies of all written statements, opinions, or records relied upon by the panel and either a transcription or other record of any oral statements or opinions; shall specify any medical or scientific authority relied upon by the panel; and shall include the results of any physical or mental

examination performed on the plaintiff. Each member shall sign the report and his signature constitutes his adoption of all statements and opinions contained in it; however, a member may, instead of signing the report, submit a concurring or dissenting report which complies with the requirements of this subsection. A member may not attest to any portion of the report as to which he is not qualified to give expert testimony.

(e) The report of the panel with any dissenting or concurring opinion is admissible in evidence to the same extent as though its contents were orally testified to by the person or persons preparing it. The court shall delete any portion that would not be admissible because of lack of foundation for opinion testimony, or otherwise. Either party may submit expert testimony to support or refute the report. The jury shall be instructed in general terms that the report shall be considered and evaluated in the same manner as any other expert testimony. Any member of the panel may be called by any party and may be cross-examined as to the contents of the report or of his dissenting or concurring opinion.

(f) No discovery may be undertaken in a case until the report of the expert advisory panel is received. However, the court may relax this prohibition upon a showing of good cause by any party. If the panel has not completed its report within the 30-day period prescribed in (b) of this section, the court may, upon application, grant it an additional 30 days.

(g) Members of a panel are entitled to travel expenses and per diem in accordance with state law pertaining to members of boards and commissions for all time spent in preparing its report. If a panel member is called upon as a witness at trial or upon deposition, he is entitled to payment of an expert witness fee, which may not exceed $150 per day. All expenses incurred by the panel shall be paid by the

court. However, in any case in which the court determines that a party has made a patently frivolous claim or a patently frivolous denial of liability, it shall order that all costs of the expert advisory panel be borne by the party making that claim or denial.

(h) Parties to the case and their counsel may not initiate communication out of court with members of the panel on the subject matter of its inquiry and report or cause or solicit others to do so, except through ordinary discovery proceedings.

* Sec. 34. AS 09.55.540 is amended to read:

Sec. 09.55.540. BURDEN OF PROOF. (a) In a malpractice action based on the negligence or wilful misconduct of a health care provider [PHYSICIAN LICENSED UNDER AS 08.64, OR A DENTIST LICENSED UNDER AS 08.-36], the plaintiff has [SHALL HAVE] the burden of proving by a preponderance of the evidence

(1) the degree of knowledge or skill possessed or the degree of care ordinarily exercised under the circumstances, at the time of the act complained of, by health care providers in the field or specialty in which the defendant is practicing [BY PHYSICIANS OR DENTISTS PRACTICING THE SAME SPECIALTY IN SIMILAR COMMUNITIES TO THAT IN WHICH THE DEFENDANT PRACTICES];

(2) that the defendant either lacked this degree of knowledge or skill or failed to exercise this degree of care; and

(3) that as a proximate result of this lack of knowledge or skill or the failure to exercise this degree of care the plaintiff suffered injuries that would not otherwise have been incurred.

(b) In malpractice actions there is [SHALL BE] no presumption of negligence on the part of the defendant.

* Sec. 35. AS 09.55 is amended by adding new sections to read:

Sec. 09.55.546. ADVANCE PAYMENTS. In an action to recover damages

under secs. 530 - 560 of this chapter, no advance payment made by the defendant health care provider or his professional liability insurer to or on behalf of the plaintiff is admissible as evidence or may be construed as an admission of liability for injuries or damages suffered by the plaintiff; however, a final award in favor of the plaintiff shall be reduced to the extent of any advance payment. The advance payment shall inure to the exclusive benefit of the defendant or the insurer making the payment.

Sec. 09.55.547. AD DAMNUM. In a cause of action against a health care provider for malpractice, the complaint or any other pleadings may not contain an ad damnum clause or monetary amount claimed against the defendant health care provider, except as necessary for jurisdictional purposes.

Sec. 09.55.548. AWARDS, COLLATERAL SOURCE. (a) Damages shall be awarded in accordance with principles of the common law. The fact finder in a malpractice action shall render any award for damages by category of loss. The court may enter a judgment that future damages be paid in whole or in part by periodic payments rather than by a lump-sum payment; the judgment shall include, if necessary, other provisions to assure that funds will be available as periodic payments become due. Insurance from an authorized insurer as defined in AS 21.90.080 or from the Medical Indemnity Corporation of Alaska is sufficient assurance that funds will be available. Any part of the award which is paid on a periodic basis shall be adjusted annually according to changes in the consumer price index in the community where the claimant resides. In this subsection, future damages includes damages for future medical treatment, care or custody, loss of future earnings, or loss of bodily function of the claimant.

(b) Except when the collateral source is a federal program which by law must seek subrogation and except death benefits paid under life insurance, a claimant may only recover damages from the defendant which

exceed amounts received by the claimant as compensation for his injuries from collateral sources, whether private, group or governmental, and whether contributory or noncontributory. Evidence of collateral sources, other than a federal program which must by law seek subrogation and the death benefit paid under life insurance, is admissible after the fact finder has rendered an award. The court [shall] May take into account the value of claimant's rights to coverage exhausted or depleted by payment of these collateral benefits by adding back a reasonable estimate of their probable value, or by earmarking and holding for possible periodic payment under (a) of this section that amount of the award that would otherwise have been deducted, to see if the impairment of claimant's rights actually takes place in the future.

* Sec. 36. AS 09.55.550 is amended to read:

Sec. 09.55.550. JURY INSTRUCTIONS. In health care [MEDICAL] malpractice actions the jury shall be instructed that the plaintiff has the burden of proving [, BY A PREPONDERANCE OF THE EVIDENCE,] the health care provider's negligence or wilful misconduct in accordance with the standard of proof specified in sec. 540 of this chapter [OF THE PHYSICIAN OR DENTIST]. The jury shall be further instructed that injury alone does not raise a presumption of the health care provider's [PHYSICIAN'S OR DENTIST'S] negligence or misconduct.

* Sec. 37. AS 09.55 is amended by adding new sections to read:

Sec. 09.55.554. ORAL CONTRACTS. No cause of action against a health care provider arises for breach of an oral contract to provide a cure or achieve a specific medical result.

Sec. 09.55.556. INFORMED CONSENT. (a) A health care provider is liable for failure to obtain the informed consent of a patient if the claimant establishes by a preponderance of the evidence that the provider has failed to inform the patient of the common risks and reasonable alternatives to the proposed treatment or procedure, and that but

for that failure the claimant would not have consented to the proposed treatment or procedure.

(b) It is a defense to any action for medical malpractice based upon an alleged failure to obtain informed consent that

(1) the risk not disclosed is too commonly known or is too remote to require disclosure;

(2) the patient stated to the health care provider that he would undergo the treatment or procedure regardless of the risk involved or that he did not want to be informed of the matters to which he would be entitled to be informed;

(3) under the circumstances consent by or on behalf of the patient was not possible; or

(4) the health care provider after considering all of the attendant facts and circumstances used reasonable discretion as to the manner and extent that the alternatives or risks were disclosed to the patient because he reasonably believed that a full disclosure would have a substantially adverse effect on the patient's condition.

Sec. 09.55.560. DEFINITIONS. In secs. 530 - 560 of this chapter

(1) "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital;

(2) "board" means an arbitration board established under sec. 535 of this chapter;

(3) "panel" means an expert advisory panel established under sec. 536 of this chapter.

* Sec. 38. AS 09.65.090 is repealed and re-enacted to read:

Sec. 09.65.090. CIVIL LIABILITY FOR EMERGENCY AID. (a) A person at a hospital or any other location who renders emergency care or emergency counseling to an injured, ill, or emotionally distraught person who reasonably appears to the person rendering the aid to be in immediate need of emergency aid in order to avoid serious harm or death is not liable for civil damages as a result of an act or omission in rendering emergency aid.

(b) This section does not preclude liability for civil damages as a result of gross negligence or reckless or intentional misconduct.

* Sec. 39. AS 18.20 is amended by adding new sections to read:

Sec. 18.20.045. INSURANCE REQUIRED. (a) Every hospital, as a condition of licensure, shall maintain and submit to the department evidence of insurance against liability to inpatients and outpatients for malpractice issued by the Medical Indemnity Corporation of Alaska, in amounts of not less than $200,000 per occurrence, and an aggregate liability per year of $1,000,000 minimum, and an additional $20,000 for each bed over 50. 1 year exemption

(b) The director of insurance or his designee shall waive the requirement in (a) of this section for a hospital if the hospital furnishes satisfactory evidence of having other insurance providing coverage in amounts not less than those specified in (a) of this section. A waiver granted under this subsection may not extend beyond the normal expiration date of the hospital's insurance policy or January 1, 1977, whichever occurs first.

(c) The director of insurance may permit a deductible provision in the policy for a hospital if the hospital

(1) demonstrates to the satisfaction of the director of insurance that without indemnity from any other source the hospital has the financial resources to discharge the maximum potential exposure to the hospital by reason of the deductible provision;

(2) agrees to permit the Medical Indemnity Corporation of Alaska to provide the defense to any claim brought against the hospital if any health care provider insured by the corporation is also involved in the claim and to reimburse the corporation for a pro rata portion of the costs of defense; and

(3) provides the Medical Indemnity Corporation of Alaska with notice of any claim brought against it.

Sec. 18.20.075. RISK MANAGEMENT. (a) To be eligible for a license each hospital shall have in operation an internal risk management program which shall

(1) investigate the frequency and causes of incidents in hospitals which cause injury to patients;

(2) develop and implement measures to minimize the risk of injury to patients; in developing these measures each hospital shall take into account recommendations of the medical staff, the Medical Indemnity Corporation of Alaska, private underwriters, industry standards, experience of other hospitals, and recommendations of licensing boards of other health care providers; and

(3) analyze patient grievances which relate to patient care.

(b) The department shall adopt by regulation and submit to the ~~legislative Administrative Regulation Review Committee standards for~~ risk management programs in hospitals in the state which may vary according to the size of the hospital, the type of care offered by the hospital, and other factors found relevant by the department.

* Sec. 40. AS 18 is amended by adding a new chapter to read:

CHAPTER 23. HEALTH CARE SERVICES INFORMATION.

Sec. 18.23.010. LIMITATION ON LIABILITY FOR PERSONS PROVIDING INFORMATION TO REVIEW ORGANIZATION. (a) No person providing information to a review organization is subject to action for damages or other relief by reason of having furnished that information, unless the information is false and the person providing the information knew or had reason to know the information was false.

(b) No privilege of confidentiality arising from a physician-patient relationship may be invoked to withhold pertinent information from review by a review organization.

Sec. 18.23.020. LIMITATION ON LIABILITY FOR MEMBERS OF REVIEW ORGANIZATIONS. No person who is a member or employee of, or who acts in an advisory capacity to, or who furnishes counsel or services to a review organization is liable for damages or other relief in an action brought by another whose activities have been or are being scrutinized or reviewed by a review organization, by reason of the performance of a duty, function or activity of the review organization, unless the performance of the duty, function or activity was motivated by malice toward the affected person. No person is liable for damages or other relief in an action by reason of his performance of a duty, function, or activity as a member of a review organization or by reason of a recommendation or action of the review organization when the person acts in the reasonable belief that the action or recommendation is warranted by facts known to the person or to the review organization after reasonable efforts to ascertain the facts upon which the review organization's action or recommendation is made.

Sec. 18.23.030. CONFIDENTIALITY OF RECORDS OF REVIEW ORGANIZATION.

(a) Except as provided in (b) of this section, all data and information acquired by a review organization, in the exercise of its duties and functions, shall be held in confidence and may not be disclosed to anyone except to the extent necessary to carry out the purposes of the review organization, and is not subject to subpoena or discovery. Except as provided in (b) of this section, no person described in sec. 20 of this chapter may disclose what transpired at a meeting of a review organization except to the extent necessary to carry out the purposes of a review organization, and the proceedings and records of a review organization are not subject to discovery or introduction into evidence in a civil action against a health care provider arising out of the matter which is the subject of consideration by the review organization. Information, documents, or records otherwise available from original sources are not immune from discovery or use in a civil action merely because they were presented during proceedings of a review organization, nor may a person who testified before a review organization or who is a member of it be prevented from testifying as to matters within his knowledge, but a witness may not be asked about his testimony before a review organization or opinions formed by him as a result of its hearings, except as provided in (b) of this section.

(b) Testimony, documents, proceedings, records, and other evidence adduced before a review organization that are otherwise inaccessible under this section may be obtained by a health care provider who claims that denial is unreasonable, or may be obtained under subpoena or discovery proceedings brought by a plaintiff who claims that information provided to a review organization was false and claims that the person providing the information knew or had reason to know the information was false.

(c) Nothing in this chapter prevents a person whose conduct or

competence has been reviewed under this chapter from obtaining, for the purpose of appellate review of the action of the review organization, any testimony, documents, proceedings, records and other evidence adduced before the review organization.

Sec. 18.23.040. PENALTY FOR VIOLATION. Other than as authorized by sec. 30 of this chapter, a disclosure of data and information acquired by a review committee or of what transpired at a review meeting is a misdemeanor and punishable under AS 11.05.010.

Sec. 18.23.050. PROTECTION OF PATIENT. Nothing in this chapter relieves a person of liability which he has incurred or may incur to a person as a result of furnishing health care to the patient.

Sec. 18.23.060. PARTIES BOUND BY REVIEW. When a review organization reviews matters under sec. 70(5)(H) of this chapter no party is bound by a ruling of the organization in a controversy, dispute or question unless he agrees in advance, either specifically or generally, to be bound by the ruling.

Sec. 18.23.070. DEFINITIONS. In this chapter, unless the context otherwise requires,

(1) "administrative staff" means the staff of a hospital or clinic;

(2) "health care" means professional services rendered by a health care provider or an employee of a health care provider, and services furnished by a sanatorium, rest home, nursing home, boarding home or other institution for the hospitalization or care of human beings;

(3) "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.-

72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital;

(4) "professional service" means service rendered by a health care provider of the type he is licensed to render;

(5) "review organization" means a hospital governing body or a committee whose membership is limited to health care providers and administrative staff, except where otherwise provided for by state or federal law, and which is established by a hospital, by a clinic, by one or more state or local associations of health care providers, by an organization of health care providers from a particular area or medical institution, or by a professional standards review organization established under 42 U.S.C., sec. 1320c-1 et seq., to gather and review information relating to the care and treatment of patients for the purposes of

(A) evaluating and improving the quality of health care rendered in the area or medical institution;

(B) reducing morbidity or mortality;

(C) obtaining and disseminating statistics and information relative to the treatment and prevention of diseases, illness and injuries;

(D) developing and publishing guidelines showing the norms of health care in the area or medical institution;

(E) developing and publishing guidelines designed to keep the cost of health care within reasonable bounds;

(F) reviewing the quality or cost of health care services provided to enrollees of health maintenance organizations;

(G) acting as a professional standards review organization under 42 U.S.C., sec. 1320c-1 et seq.;

(H) reviewing, ruling on, or advising on controversies, disputes or questions between

(i) a health insurance carrier or health maintenance organization and one or more of its insured or enrollees;

(ii) a professional licensing board, acting under its powers of discipline or license revocation or suspension, and a health care provider licensed by it when the matter is referred to a review organization by the professional licensing board;

(iii) a health care provider and his patients concerning diagnosis, treatment or care, or a charge or fee;

(iv) a health care provider and a health insurance carrier or health maintenance organization concerning a charge or fee for health care services provided to an insured or enrollee; or

(v) a health care provider or his patients and the federal or a state or local government, or an agency of the federal or a state or local government;

(I) acting on the recommendation of a credential review committee or a grievance committee.

* Sec. 41. AS 21 is amended by adding a new chapter to read:

CHAPTER 88. HEALTH CARE PROVIDERS INSURANCE.

ARTICLE 1. PURPOSE.

Sec. 21.88.010. PURPOSE OF CHAPTER. It is the purpose of this chapter to provide a means of furnishing health care providers with adequate insurance against liability for medical negligence.

ARTICLE 2. MEDICAL INDEMNITY CORPORATION OF ALASKA.

Sec. 21.88.020. CORPORATION CREATED. There is created the Medical Indemnity Corporation of Alaska which is a public corporation having a legal existence independent of and separate from the state. Obligations issued by the corporation do not constitute a debt, liability or obligation of the state or a pledge of full faith and credit of the state.

Sec. 21.88.030. CORPORATION BOARD OF GOVERNORS. (a) The corporation shall exercise its powers through a board of governors which is appointed by the governor of the state and confirmed by the legislature. Members of the board of governors shall be Alaska residents as follows:

(1) two physicians licensed in the state; one of the physicians shall be engaged in group practice in a clinic of six or more physicians;

(2) an administrator or senior executive officer employed by a hospital licensed in the state;

(3) two professionals from insurance companies authorized in the state;

(4) two persons who are not health care providers or financially interested in the field of health care or representatives of the insurance industry.

(b) The term of office of each governor is three years, except that the governor of the state shall designate two initially appointed governors to serve for one year and two initially appointed governors to serve for two years. Upon the expiration of the term of a governor, the governor of the state shall appoint a successor who shall be from the same class described in (a) of this section as the governor whose term has expired.

(c) Upon a governor's early resignation, death or inability to

serve, the governor of the state shall appoint a successor from the same class defined in (a) of this section as the terminating governor, who shall serve for the unexpired term.

(d) The director or his designee is not a voting member of the board of governors but shall be notified by the board of and have the right to attend and participate in all meetings and proceedings of the board.

(e) Members of the board of governors receive compensation from the corporation of $100 per day when the board meets and necessary travel expenses.

Sec. 21.88.040. CORPORATION PLAN OF OPERATION. (a) Within 30 days after the effective date of this chapter, the board of governors shall prepare and submit to the director for approval a plan of operation which provides for the fair, reasonable and equitable administration of the affairs of the corporation and the discharge of the purposes for which it is created. The plan and any amendments to it become effective upon the director's approval. If the board of governors fails to submit a plan of operation, or if at a subsequent time the board of governors fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate a plan of operation or amendments which are necessary or advisable to carry out the provisions of this chapter. Adoption of the plan is not subject to the Administrative Procedure Act (AS 44.62).

(b) The plan of operation shall

(1) establish the procedures by which all the powers and duties of the corporation specified in sec. 50 of this chapter shall be performed;

(2) establish procedures for handling assets and discharging liabilities of the corporation;

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(3) establish regular times and places for meetings of the board of governors;

(4) establish procedures for records to be kept of all financial transactions of the corporation, its agents, and the board of governors;

(5) establish the procedures for awarding contracts to carry out the provisions of this chapter;

(6) establish the procedures for issuing contracts of insurance as provided in sec. 50 of this chapter and for the determination of rates;

(7) contain additional provisions necessary for the execution of the powers and duties of the corporation.

Sec. 21.88.050. POWERS AND DUTIES OF THE CORPORATION. (a) The corporation shall

(1) in the form approved by the director, issue to all physicians and hospitals who pay the premiums for it a contract or contracts indemnifying the physicians and hospitals and their employees who are physicians against loss by reason of liability for professional services on an occurrence basis and agreeing to tender on behalf of th physicians and hospitals and their employees who are physicians a defense in a proceeding brought under AS 09.55.530 - 09.55.560; the limit of liability shall be no less than the minimum liability coverage requirements to be maintained under AS 08.64.215 and AS 18.20.045; the contract shall cover the defense against but need not indemnify a claim for punitive damages; at the option of the physician or hospital and for an additional premium the contract may cover claims against the physician or hospital that arise out of professional services performed by the physician or hospital after December 31, 1974 except that coverage will not be provided for a claim already filed or of which the physician or

hospital had or reasonably should have had notice at the time the retroactive insurance was purchased;

(2) in a form approved by the director and for a premium determined under sec. 80 of this chapter, issue contracts of insurance on an occurrence basis indemnifying chiropractors, dental hygienists, dentists, nurses, dispensing opticians, optometrists, pharmacists, physical therapists, or psychologists and psychological associates, if a finding of unavailability of insurance and impairment of services has been made under AS 08.20.115, AS 08.32.015, AS 08.36.115, AS 08.68.165, AS 08.71.085, AS 08.72.115, AS 08.80.115, AS 08.84.035, or AS 08.86.125; and agreeing to tender on behalf of the person insured under this paragraph a defense in a proceeding under AS 09.55.530 - 09.55.560; the contract shall cover the defense against but need not indemnify a claim for punitive damages;

(3) charge a premium for the protection provided by the contracts issued by the corporation which shall be determined by the board of governors in accordance with sec. 80 of this chapter and subject to the approval of the director;

(4) comply with or be subject to AS 21.06.090; 21.06.120; 21.06.140; 21.06.160; 21.06.250; AS 21.09.180; 21.09.190; 21.09.200; 21.09.250; 21.09.280; AS 21.12.020(b), (c), (d), and (e); and chs. 18, 21, 24, and 36 of this title; and shall be exempt from participation as a member insurer in the Alaska Insurance Guaranty Corporation;

(5) carry out the obligations of the contracts issued by the corporation by defending all covered claims made against insured health care providers and by paying all liabilities which are finally adjudicated against the insured health care provider or which may in the opinion of the corporation reasonably be expected to be finally adjudicated against the health care provider to the extent of the contract

obligation;

(6) provide coverage to physicians and hospitals for liability in excess of the minimum limits required for licensure as a physician or hospital, but limited to $1,000,000 for physicians and $5,000,000 for hospitals, if there is a finding by the director that this coverage is unavailable at a reasonable cost and that this coverage can be made available at a reasonable cost through the corporation; if this paragraph is implemented, then each physician or hospital obtaining excess coverage up to these amounts shall obtain it from the corporation, and the corporation may procure reinsurance for all risks incurred by contracts issued under this paragraph from the private market.

(b) The corporation may

(1) employ or retain persons, individual or corporate, to discharge its obligations and pay reasonable compensation for those services; employees of the corporation are not considered state employees;

(2) recommend that the director hold public hearings for the purpose of commencing operation of the joint underwriting association established under secs. 110 - 180 of this chapter; if the joint underwriting association begins operation, the corporation may purchase reinsurance from the association for any of the liability incurred by contracts issued by the corporation;

(3) provide coverage to physicians and hospitals for other hazards when there is a finding by the director that this coverage is otherwise unavailable by reason of the operation of the corporation;

(4) borrow or advance funds necessary to carry out the purposes of the corporation;

(5) negotiate and become a party to those contracts as are necessary to carry out the purposes of the corporation;

(6) sue or be sued in the name of the corporation;

(7) provide risk management advice and services to hospitals;

(8) negotiate and become a party to contracts for management services for the corporation;

(9) perform all other acts necessary and proper to ~~effectuate~~ carry out the duties of the corporation.

Sec. 21.88.060. PREMIUM TAX. The corporation shall pay a premium tax in the amount of one and one-half per cent of the total direct premium income received by the corporation during the year ending on the preceding December 31, after deducting the applicable cancellations, returned premium, the unabsorbed portion of any deposit premiums, all policy dividends, unabsorbed premiums refunded to policyholders, refunds, savings, savings coupons and other similar returns paid or credited to policyholders with respect to their policies. The tax shall be paid to the director annually before April 1 of each year.

Sec. 21.88.070. STATISTICS. The corporation shall collect, maintain and report information concerning claims against health care providers. The information shall be on forms prescribed by the director, and shall be sufficient to enable a proper determination of losses for rate making and to identify causes and sources of loss for loss control. At least annually the corporation shall report to the director the number and amount of claims filed, reserved, paid, settled and adjudicated during the year, the premiums paid to and the expenses incurred by the corporation during the year. This report shall be available to the public. The director may require that supplemental reports include the names of insured health care providers and the claimants; however, no reports which become available to the public may include the names of health care providers or claimants or information that will permit by inference the identity of specific health care

providers or claimants. All statistics shall be made available to the appropriate licensing board or agency.

Sec. 21.88.080. RATES. The rates and rating plans used by the corporation for the policies issued shall be determined by license category of health care providers in accordance with all of the following:

(1) rates for physicians shall be set as a function of the physician's medical revenue;

(2) rates for hospitals shall be set as a function of the number of permanent beds in the hospital;

(3) a minimum rate may be set for each category of health care provider or discipline or classification within the license category;

(4) rates may not be excessive; rates are excessive if, after a period of time and with respect to an amount of gross premium which are actuarially credible, the premiums exceed losses incurred by the corporation, including losses paid, reserves for claims reported and unpaid, reserves for claims incurred during the policy period and not reported, provided that reserves for claims incurred during the policy period and reasonably expected to be reported after three years after the incident may be included on a different basis due to the additional financial flexibility provided by the corporation, and reasonable expenses for the operation of the corporation;

(5) rates shall not be inadequate; rates are inadequate if, based on available actuarial data, the premiums to be paid by the health care providers are or may reasonably be expected to be insufficient to pay for losses incurred by the corporation, including claims paid, reserves for claims reported and unpaid, reserves for claims incurred during the policy period and not reported, provided that reserves for claims incurred during the policy period and reasonably

expected to be reported after three years after the incident may be included on a different basis due to the additional financial flexibility provided by the corporation, and reasonable expenses for the operation of the corporation;

(6) rates may not be unfairly discriminatory;

(7) rates shall be adjusted annually;

(8) rates for any policy year shall be calculated to include the adjustment for actual experience of the corporation as developed for the preceding four policy years;

(9) in considering losses to be incurred, changes in the law, national, regional or local trends in medical negligence awards, and other relevant factors may be considered;

(10) income from the investment of reserves shall be considered;

(11) individual risk underwriting factors shall be considered;

(12) disciplines and classifications within the license categories of health care providers shall be considered;

(13) amounts sufficient for repayment of loan obligations shall be considered.

Sec. 21.88.090. PAYMENT OF PREMIUMS; CANCELLATION OF INSURANCE. The corporation may provide for installment payment of premiums in which event each installment is due by the date specified. The corporation may cancel any of its policies in the event of nonpayment of any premium or installment on a premium, or other charge, by mailing or delivering to the insured at the address shown on the policy and to the agency of the state issuing the insured's license written notice of cancellation. Cancellation is not effective until 30 days after the date notice is posted by the corporation.

ARTICLE 3. JOINT UNDERWRITING ASSOCIATION.

Sec. 21.88.110. ASSOCIATION CREATED. (a) The Health Care Providers Joint Underwriting Association is created as an association having a legal existence independent of and separate from the state and consisting of all licensed (1) health care service corporations as defined in AS 21.87.330; (2) disability insurers as defined in AS 21.12.050; (3) property insurers as defined in AS 21.12.060; and (4) casualty insurers as defined in AS 21.12.070. Obligations issued by the association do not constitute a debt, liability or obligation of the state or a pledge of full faith and credit of the state.

(b) Every insurer described in (a) of this section is a member of the association and shall remain a member as a condition of its authority to continue to transact that kind of business in the state.

(c) The association shall commence operation if the director finds, after public hearing, that a market for reinsurance is needed by the corporation. After the association has commenced operation, if the director determines, after public hearing, that a market for reinsurance is no longer needed by the corporation, the association shall cease its underwriting operations.

Sec. 21.88.120. PURPOSE. The purpose of the association is to provide a market for medical malpractice reinsurance to the corporation on a self-supporting basis without subsidy from association members.

Sec. 21.88.130. ASSOCIATION BOARD OF DIRECTORS; TERM; COMPENSATION. (a) The association shall be governed by a board of directors appointed by the governor of the state and consisting of two representatives of domestic casualty and property insurers, one representative of admitted disability insurers, one representative of health care service corporations, one representative of foreign casualty and property insurers, and two persons from the public.

(b) Members of the board of directors serve three-year terms.

(c) Members of the board of directors receive compensation from the association of $100 per day when the board meets and necessary travel expenses.

Sec. 21.88.140. ASSOCIATION PLAN OF OPERATION. (a) Within 30 days after the association commences operation the board of directors shall prepare and submit to the director for his approval a plan of operation which provides for the fair, reasonable and equitable administration of the affairs of the association and the discharge of the purposes for which it is created. The plan and any amendments to it become effective upon the director's approval. If the board of directors has failed to submit a plan of operation, or if at any subsequent time the board of directors fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate a plan of operation or amendments which are necessary or advisable to carry out the provisions of this chapter. Adoption of the plan is not subject to the Administrative Procedure Act (AS 44.62).

(b) The plan of operation shall

(1) establish the procedures for carrying out the powers and duties of the association specified in sec. 150 of this chapter;

(2) establish procedures for handling assets and discharging liabilities of the association;

(3) establish regular times and places for meetings of the board of directors;

(4) establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(5) establish the procedures for awarding contracts to indemnify or defend or to provide other services and to compensate the indemnitors or vendors;

(6) establish the procedures for issuing contracts of insurance as provided in sec. 150 of this chapter and for the determination of rates;

(7) contain additional provisions necessary for the execution of the powers and duties of the association.

Sec. 21.88.150. POWERS AND DUTIES OF THE ASSOCIATION. (a) The association shall

(1) provide reinsurance to the corporation covering contracts issued by the corporation for that portion of the liability incurred by the corporation it chooses to reinsure through the association, indemnifying physicians and hospitals, their employees who are physicians, and other persons insured by the corporation against loss by reason of liability for professional services and agreeing to tender on behalf of the insureds a defense in an action brought under AS 09.55.530 - 09.55.-560;

(2) charge a premium for the protection provided by the reinsurance issued under (a)(1) of this section which shall be determined by the board of directors in accordance with secs. 80 and 160 of this chapter and are subject to the approval of the director;

(3) comply with or be subject to AS 21.06.090; 21.06.120; 21.06.140; 21.06.160; 21.06.250; AS 21.09.180; 21.09.200; 21.09.250; 21.09.280; AS 21.12.020(b), (c), (d), and (e); and chs. 18, 21, 24, and 36 of this title; and shall be exempt from participation as a member insurer in the Alaska Insurance Guaranty Association;

(4) carry out the obligations of the contracts issued under (a)(1) of this section by defending all covered claims made against the insureds and paying all liabilities which are finally adjudicated against the insureds or which may in the opinion of the association reasonably be expected to be finally adjudicated against the insured

to the extent of the contract obligation.

(b) The association may

(1) employ or retain persons, individual or corporate, to discharge its obligations and pay reasonable compensation for those services; employees of the association are not considered state employees;

(2) borrow or advance funds necessary to carry out the purposes of ~~this~~ the association;

(3) negotiate and become a party to those contracts which are necessary to carry out the purposes of the association;

(4) sue or be sued in the name of the association;

(5) cede or assume reinsurance;

(6) perform all other acts necessary and proper to carry out the duties of the association.

Sec. 21.88.160. RATES AND RATE ADJUSTMENT. (a) The rates and rating plans shall be determined as provided in sec. 80 of this chapter, except that allowance may not be made for income from investment of member-contributed funds; and provided that reserves for claims incurred during the policy period and reasonably expected to be reported after three years after the incident may be included on a different basis due to the additional financial flexibility provided by the association.

(b) If in any year an assessment is made under sec. 170 of this chapter, rates for the next period shall be increased from the rate determined under (a) of this section by an amount sufficient to reimburse all members the amounts assessed. No assessment may be reimbursed to members without prior approval of the director and no interest accrues in favors of members on amounts assessed.

(c) If after establishing required reserves and repaying all assessments to members there is an excess amount in reserve, the excess

premium shall be refunded to the ~~association for reimbursement to the insureds~~ corp.

Sec. 21.88.170. ASSESSMENT. If sufficient funds are not available for the sound financial operation of the association, all members shall contribute to the financial requirements of the association by paying to the association an assessment to be determined by the board of directors of the association, subject to the approval of the director; assessments shall be prorated among all members in proportion to their direct written premiums or revenues in the state in the insurance lines the writing of which require membership in the association, in the two years ending on the preceding December 31, after deducting the applicable cancellations, returned premium, the unabsorbed portion of any deposit premium, all policy dividends, unabsorbed premiums refunded to policyholders, refunds, savings, savings coupons and other similar returns paid or credited to policyholders with respect to their policies. If any member is prohibited by the law of its state of domicile from paying an assessment to the association, then in lieu of the assessment the member shall pay a tax to the director in a like amount as an obligation in addition to taxes required under AS 21.09.210 and notwithstanding the provisions of AS 21.09.210(e). ~~Taxes received under this section~~ An Amount equal to Taxes received under this section shall then be appropriated to the association.

Sec. 21.88.180. REPORTS. At least annually the association shall report to the director concerning its affairs. The report shall be in the form prescribed by the director.

ARTICLE 4. LOAN FUND.

Sec. 21.88.210. FUND ESTABLISHED. (a) There is in the Department of Commerce and Economic Development a medical malpractice liability revolving loan fund to be administered by the director of insurance.

(b) Loans may be made from the fund to the corporation and to the

association upon certification by the director that a loan is necessary for the corporation or association to spread costs out over time because of fluctuations in loss experience. If a loan is made to the corporation or the association from the fund, the borrower shall issue a note to the fund as evidence of the loan.

(c) Loans from the fund shall be repaid within five years at an annual interest rate of six per cent.

(d) The director may sell at par value to the Department of Revenue the notes, security instruments and pledge agreements held by the Department of Commerce and Economic Development as security for loans made under this section. The Department of Revenue shall purchase all the notes offered until the current principal amount of the notes purchased and held by the Department of Revenue equals $5,000,000.

ARTICLE 5. GENERAL PROVISIONS.

Sec. 21.88.900. DEFINITIONS. In this chapter

(1) "association" means the Health Care Providers Joint Underwriting Association;

(2) "corporation" means the Medical Indemnity Corporation of Alaska;

(3) "governor" means a member of the board of governors of the Medical Indemnity Corporation of Alaska;

(4) "health care provider" means a person or institution insured under this chapter;

(5) "physician" means a person licensed under AS 08.64;

(6) "hospital" means an institution licensed under AS 18.20;

(7) "chiropractor" means a person licensed under AS 08.20;

(8) "dental hygienist" means a person licensed under AS 08.32;

(9) "dentist" means a person licensed under AS 08.36;

(10) "dispensing optician" means a person licensed under

AS 08.71;

(11) "optometrist" means a person licensed under AS 08.72;

(12) "physical therapist" means a person licensed under AS 08.80;

(13) "pharmacist" means a person licensed under AS 08.84;

(14) "psychologist" and "psychological associate" means a person licensed under AS 08.86.

* Sec. 42. AS 21.18.090 is amended by adding new paragraphs to read:

(5) reserves for the Medical Indemnity Corporation of Alaska are to include only reserves for claims reported and unpaid and reserves for claims incurred but not reported but which may reasonably be expected to be reported within three years after the date of occurrence;

(6) reserves for the Health Care Providers Joint Underwriting Association are to include claims reported and unpaid; reserves for claims incurred but not reported, but those which may reasonably be expected to be reported beyond three years after the date of occurrence may be included on a different basis due to the additional financial flexibility of the association

* Sec. 43. AS 21.80.180(5) is amended to read:

(5) "insolvent insurer" means an insurer

(A) authorized to transact insurance in this state, except the Medical Indemnity Corporation of Alaska and the Health Care Providers Joint Underwriting Association established under ch. 88 of this title, either at the time the policy was issued or when the insured event occurred, and

(B) determined to be insolvent by a court of competent jurisdiction;

* Sec. 44. AS 21.80.180(6) is amended to read:

(6) "member insurer" means a person, except the Medical

Indemnity Corporation of Alaska and the Health Care Providers Joint Underwriting Association established under ch. 88 of this title, who

(A) writes any kind of insurance to which this chapter applies under sec. 20 of this chapter including the exchange of reciprocal or inter-insurance contracts, and

(B) is licensed to transact insurance in this state;

* Sec. 45. AS 08.02 is amended by adding a new section to read:

Sec. 08.02.020. LIMITATION OF LIABILITY FOR MEMBERS OF LICENSING BOARDS. No person is liable for damages or other relief in an action by reason of his performance of a duty, function, or activity as a member of a licensing board or by reason of a recommendation or action of the board when the person acts in the reasonable belief that his action or recommendation is warranted by facts known to him or to the board after reasonable efforts to ascertain the facts upon which the action or recommendation is made.

* Sec. 46. AS 09.55.536, enacted in sec. 33 of this Act, has the effect of changing the Alaska Supreme Court's Rules of Civil Procedure by requiring the submission of medical malpractice actions against health care providers to expert advisory panels before discovery unless the court decides an expert advisory opinion is not necessary in the case.

* Sec. 47. AS 08.64.365 and AS 08.68.040 are repealed.

* Sec. 48. This Act takes effect 30 days after enactment.

Original Sponsor: Rules Committee by request of the Governor

IN THE HOUSE BY THE FREE CONFERENCE COMMITTEE

FREE CONFERENCE CS FOR SENATE CS FOR CS FOR HOUSE BILL NO. 574

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to health care; changing the Alaska Supreme Court's Rules of Civil Procedure; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 08.01.050 is amended by adding a new paragraph to read:

(19) provide investigative services to the boards established under chs. 20, 32, 36, 64, 68, 71, 72, 80, 84, and 86 of this title, for the purpose of assisting those boards in matters of professional discipline.

* Sec. 2. AS 08.20.010 is amended to read:

Sec. 08.20.010. CREATION AND MEMBERSHIP OF BOARD OF CHIROPRACTIC EXAMINERS. There is created the Board of Chiropractic Examiners consisting of <u>five</u> [THREE] members appointed by the governor.

* Sec. 3. AS 08.20.020 is amended to read:

Sec. 08.20.020. MEMBERS OF BOARD. <u>Three members</u> [EACH MEMBER] of the board shall be [A] licensed chiropractic <u>physicians who</u> [PHYSICIAN AND SHALL] have practiced chiropractic in this state not less than two years. <u>Two members of the board shall be persons with no direct financial interest in the health care industry.</u> Each member serves without pay but is entitled to per diem and travel expenses allowed by law.

* Sec. 4. AS 08.20.030 is repealed and re-enacted to read:

Sec. 08.20.030. MEMBERS TERMS, VACANCIES. Members serve for staggered terms of three years. The terms of the public members of the board may not expire at the same time. Vacancies on the board shall be

filled for the unexpired term.

The House bill requires ~~chiropractors~~ ~~dental hygienists~~ to carry malpractice insurance at least $200,000/$600,000; if this not available they are opted on to the corporation (and engagement services)

* Sec. 5. AS 08.20 is amended by adding a new section to read:

Sec. 08.20.175. LIMITS OR CONDITIONS ON LICENSE; REPRIMAND. (a) In addition to action under sec. 170 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education or health the authority to practice chiropractic should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

The House bill requires dental hygienists to carry malpractice insurance at least $150,000/300,000, if this not available (and engagement services) they are opted on to the corporation.

* Sec. 6. AS 08.32 is amended by adding a new section to read:

Sec. 08.32.165. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 160 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education or health the authority to practice dental hygiene should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 7. AS 08.36.010 is amended to read:

Sec. 08.36.010. CREATION AND MEMBERSHIP OF BOARD. There is created the Board of Dental Examiners, referred to in this chapter as the board, consisting of <u>seven</u> [FIVE] members. <u>Five members</u> [EACH MEMBER] shall be [A CITIZEN OF THE UNITED STATES AND A] qualified resident <u>dentists</u> who <u>have</u> [HAS] been engaged in the practice of dentistry in the state for five years immediately preceding [HIS] appointment<u>, and two members shall be persons with no direct financial interest in the health care industry</u>.

* Sec. 8. AS 08.36.020 is amended to read:

Sec. 08.36.020. APPOINTMENT AND TERM OF SERVICE OF MEMBERS. Members of the board are appointed by the governor, subject to confirmation by the legislature in joint session [ASSEMBLED]. Each board member serves for a term of five years, and until his successor is appointed and qualified <u>except that the terms of the public members on the board shall be staggered so that they do not expire at the same time</u>. The term begins on February 1. An appointment to a vacancy is for the unexpired term. [APPOINTMENTS SHALL BE MADE FROM A LIST OF NAMES RECOMMENDED BY THE ALASKA DENTAL SOCIETY. THE LIST SHALL BE

SUPPLIED AT LEAST 30 DAYS BEFORE THE BEGINNING OF A TERM AND NOT MORE THAN 60 DAYS AFTER THE OCCURRENCE OF A VACANCY. THE LIST SHALL CONTAIN AT LEAST TWO RECOMMENDED NAMES FOR EACH APPOINTMENT. THE GOVERNOR SHALL MAKE THE APPOINTMENT WITHIN 30 DAYS AFTER RECEIVING THE LIST.]

The House bill requires dentists to carry malpractice insurance (at least $200,000/$600,000, if it's not available) or are opted in to the corporation

* Sec. 9. AS 08.36 is amended by adding a new section to read:

Sec. 08.36.325. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 320 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health, the authority to practice dentistry should be limited or conditioned or the practitioner disciplined, the board may censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 10. AS 08.64.010 is amended to read:

Sec. 08.64.010. CREATION AND MEMBERSHIP OF STATE MEDICAL BOARD. The governor shall appoint a board of medical examiners, to be known as the State Medical Board, consisting of five licensed physicians, residing in as many separate Alaska judicial districts as possible, and two persons with no direct financial interest in the health care industry.

[EACH MEMBER SHALL BE CHOSEN FROM A PANEL OF THREE, FOR EACH VACANCY, SUBMITTED TO THE GOVERNOR BY THE ALASKA STATE MEDICAL ASSOCIATION.]

* Sec. 11. AS 08.64.020 is amended to read:

Sec. 08.64.020. STATE MEDICAL BOARD TERM OF OFFICE. Members shall be appointed for a term of four years, subject to confirmation by a majority of the members of the legislature in joint session, and shall hold office until their successors are appointed and qualified. The terms of the public members of the board shall be staggered so that they do not expire at the same time.

* Sec. 12. AS 08.64.090 is amended to read:

Sec. 08.64.090. QUORUM. Four [THREE] members of the board constitute a quorum for the transaction of all business properly before the board.

* Sec. 13. AS 08.64 is amended by adding new sections to read:

Sec. 08.64.215. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person shall maintain insurance issued by the Health Care Providers Indemnity Corporation against liability to patients for medical malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him him from the Health Care Providers Indemnity Corporation in the required amounts.

(b) The director of insurance or his designee shall waive the requirement in (a) of this section for a person if that person furnishes satisfactory evidence of his having other insurance providing coverage in amounts not less than those specified in (a) of this section. No waiver granted under this subsection may extend beyond the normal expiration date of the person's insurance policy or January 1, 1977, whichever occurs first.

Sec. 08.64.312. CONTINUING EDUCATION REQUIREMENTS. (a) The board shall promote a high degree of competence in the practice of medicine by requiring every physician licensed in the state to fulfill continuing education requirements.

(b) Before a license may be renewed the licensee shall submit evidence to the board that continuing education requirements prescribed by regulations adopted by the board have been met.

(c) The board may exempt a physician from the requirements of (b) of this section upon an application by him giving evidence satisfactory to the board that he is unable to comply with the requirements because of extenuating circumstances. However, no person may be exempted from more than 15 hours of continuing education in a five-year period.

Sec. 08.64.325. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 330 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 14. AS 08.68.010 is amended to read:

Sec. 08.68.010. CREATION AND MEMBERSHIP OF BOARD OF NURSING. There is created a Board of Nursing, consisting of <u>seven</u> [FIVE] members appointed by the governor. One member shall be currently involved in institutional nursing service, one member in community or public health nursing and two members in basic or continuing nursing education, [AND] one <u>nurse</u> at large<u>, and two persons who have no direct financial interest</u>

in the health care industry.

* Sec. 15. AS 08.68.020 is repealed and re-enacted to read:

Sec. 08.68.020. TERM OF OFFICE. Members serve staggered terms of five years and until their successors are appointed. The terms of the public members on the board shall be set so that they do not expire at the same time. Vacancies on the board shall be filled for the unexpired term.

* Sec. 16. AS 08.68.060 is amended to read:

Sec. 08.68.060. QUALIFICATIONS OF BOARD MEMBERS. The five members [EACH MEMBER] of the board who are nurses shall be [A CITIZEN OF THE UNITED STATES, A RESIDENT OF THE STATE, AND A] licensed professional nurses [NURSE] in the state, and [. MEMBERS] shall have been actively engaged in nursing for not less than four years before appointment, two years of which were within the five years preceding appointment.

The House Bill requires nurses to carry insurance [Unemployment] Benefits of $100,000/$300,000; if it is not available they are exempt from the requirement.

* Sec. 17. AS 08.68 is amended by adding a new section to read:

Sec. 08.68.275. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 270 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice nursing should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place

on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 18. AS 08.71.020 is amended to read:

Sec. 08.71.020. MEMBERSHIP OF BOARD; SOURCE OF APPOINTMENTS; TERM OF OFFICE. The board consists of seven [FIVE] persons appointed by the governor. Members serve staggered terms of three years. The terms of the public members of the board shall be set so that they do not expire at the same time. [THE GOVERNOR SHALL APPOINT BOARD MEMBERS FROM A LIST OF QUALIFIED OPTICIANS PREPARED BY THE ASSOCIATION OF OPTICIANS IN THE STATE AND SUBMITTED AT LEAST 30 DAYS BEFORE JULY 1, 1973, AT LEAST 30 DAYS BEFORE THE EXPIRATION OF A TERM AND NOT MORE THAN 60 DAYS AFTER A VACANCY OCCURS IN AN UNEXPIRED TERM. THE LIST SHALL CONTAIN NOT LESS THAN TWO RECOMMENDED CANDIDATES FOR EACH APPOINTMENT. THE GOVERNOR SHALL MAKE APPOINTMENTS WITHIN 30 DAYS AFTER RECEIVING THE LIST. THE TERM OF OFFICE OF EACH MEMBER IS THREE YEARS. HOWEVER, OF THE FIRST MEMBERS OF THE BOARD, ONE SHALL BE APPOINTED FOR A ONE-YEAR TERM, TWO FOR TWO-YEAR TERMS, AND TWO FOR THREE-YEAR TERMS.] Vacancies on the board shall be filled for the unexpired term [IN THE SAME MANNER AS ORIGINAL APPOINTMENT].

* Sec. 19. AS 08.71.030 is amended to read:

Sec. 08.71.030. QUALIFICATIONS OF BOARD MEMBERS. Five [A] board members [MEMBER] shall be [A] licensed, practicing dispensing opticians [OPTICIAN] residing in the state. Two shall be persons with no direct financial interest in the health care industry.

The House bill requires dispensing opticians to carry malpractice insurance of $100,000/$300,000, (and in impairment of services) if it is unavailable, they are opted into the corporation.

* Sec. 20. AS 08.71 is amended by adding a new section to read:

Sec. 08.71.175. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 170 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice as a dispensing optician under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 21. AS 08.72.020 is amended to read:

Sec. 08.72.020. MEMBERSHIP OF BOARD AND TERMS OF OFFICE. The board consists of <u>five</u> [THREE] persons, appointed by the governor. <u>Members serve staggered terms of three years. The terms of the public members of the board shall be set so that they do not expire at the same time.</u> [THE TERM OF EACH MEMBER IS THREE YEARS. ONE MEMBER ONLY IS APPOINTED EACH YEAR, EXCEPT WHEN VACANCIES FOR UNEXPIRED TERMS ARE FILLED.]

* Sec. 22. AS 08.72.040 is repealed and re-enacted to read:

Sec. 08.72.040. QUALIFICATIONS. Three board members shall be licensed, practicing optometrists who have been residents for at least three years. Two shall be persons who have no direct financial interest in the health care industry.

The House bill requires optometrists to carry medical malpractice insurance or equivalent (and in equivalent of insurance) $100,000/$300,000, if it is not available, they are opted into the corporation.

* Sec. 23. AS 08.72 is amended by adding a new section to read:

Sec. 08.72.255. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under secs. 240 and 250 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice optometry under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 24. AS 08.80.010 is amended to read:

Sec. 08.80.010. CREATION AND MEMBERSHIP OF BOARD OF PHARMACY. There is created the Board of Pharmacy, composed of <u>seven</u> [FIVE] members,

five [EACH] of whom shall be pharmacists [A PHARMACIST] licensed in the state who has been actively engaged in the practice of pharmacy in the state for a period of three years immediately preceding his appointment. Two shall be persons with no direct financial interest in the health care industry. Whenever possible, the board shall include at least one member from each judicial district.

* Sec. 25. AS 08.80.020 is amended to read:

Sec. 08.80.020. TERM OF OFFICE. Members of the board are appointed by the governor, and confirmed by the legislature in joint session, for overlapping terms of five years, or until their successors are appointed and qualified. The terms of the public members shall be staggered so that they do not expire at the same time. An appointment to fill a vacancy is for the unexpired term. The term of office begins on April 1 of each year.

The House bill requires pharmacists to carry malpractice insurance of $100,000/$300,000, and no impairment of service if they are not included in the negotiations

* Sec. 26. AS 80.80 is amended by adding a new section to read:

Sec. 08.80.265. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 260 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice pharmacy under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

The House bill requires physical therapists to carry malpractice insurance of $100,000/$300,000, if it is not available (and there is no government service) they are opted in to the corporation.

* Sec. 27. AS 08.84 is amended by adding a new section to read:

Sec. 08.84.185. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 180 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education or health the authority to practice physical therapy should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 28. AS 08.86.010 is amended to read:

Sec. 08.86.010. CREATION AND MEMBERSHIP OF BOARD. There is created a Board of Psychologist and Psychological Associate Examiners. It consists of three licensed psychologists, and two persons who have no direct financial interest in the health care industry.

* Sec. 29. AS 08.86.020 is amended to read:

Sec. 08.86.020. APPOINTMENT AND TERM OF OFFICE. Members of the board are appointed by the governor and confirmed by the legislature for staggered terms of three years. The terms of the public members shall be set so that they do not expire at the same time. A member serves at the pleasure of the governor.

The House bill requires psychologists and psychological associates to carry malpractice insurance of $100,000/$300,000; (and there is no comparable provision) if it is not available, they are exempted from the requirement.

* Sec. 30. AS 08.86 is amended by adding a new section to read:

Sec. 08.86.220. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) Upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice psychology or as a phsychological associate under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by time, specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

to an expert advisory panel, to be appointed by the court. Panel expenses are paid by the State.

The Senate bill provided for either arbitration or submission to an expert advisory panel as follows:

* Sec. 31. AS 09.55 is amended by adding new sections to read:

Sec. 09.55.535. MANDATORY ARBITRATION. (a) It is the purpose of these arbitration provisions to establish a system that will provide incentives to settle malpractice disputes without prolonged litigation and that will provide a method by which parties to a medical malpractice claim can obtain a prompt determination of its merits, and the amount of damages, if any, that should be allowed.

(b) Upon the filing of any malpractice claim against a physician or hospital, the claim shall be submitted to an arbitration board; however, submission to an arbitration board may not be required if all parties object to arbitration or if the parties have agreed to follow the procedures prescribed in sec. 536 or sec. 537 of this chapter.

(c) The arbitration board shall consist of three arbitrators: one arbitrator designated by the plaintiff or plaintiffs, one arbitrator designated by the defendant or defendants, and a third arbitrator designated by mutual agreement who shall serve as chairman of the

board. If the parties cannot agree on the third person, the court will provide a list of three or more persons who might serve as chairman of the arbitration board, which shall be furnished by the attorney general. Plaintiff or plaintiffs together and defendant and defendants together may each strike one or more names from the list, so after each side has done so, at least one name remains on the list, providing a basis for the final selection by the court.

(d) The attorney general shall prepare a list of panelists consisting of lawyers or other persons qualified to serve as chairmen of arbitration boards. They shall be selected on basis of their technical expertise, judicial temperament, and capability of impartially acting on malpractice claims. The attorney general shall submit a list of at least three names of panelists whenever requested to do so by the court along with detailed biographical information on each panelist.

(e) Each member of the board shall receive reasonable compensation to be paid by the court based on the extent and duration of services rendered. The court shall also pay the costs of experts required by the board.

(f) The board may appoint an expert advisory panel, with the powers of the expert advisory panel under sec. 537 of this chapter, to advise the board on the medical facts of the case.

(g) The court shall specify the shortest practical deadline for completion of the work of the arbitration panel, taking into account all the circumstance and the nature of the case.

(h) The provisions of the Uniform Arbitration Act, AS 09.43.010 - 09.43.180, apply to arbitrations under this section insofar as they are applicable and do not conflict with the provisions of this section; arbitrations under this section shall be conducted in accordance with any rules of court which may be adopted.

(i) If the decision of the arbitration board is not accepted by all parties and the parties have not agreed to binding arbitration, any party may appeal the decision of the board to the superior court for a trial de novo. The decision of the arbitration board, including its conclusions as to the merits of the claim and appropriate damages, together with any dissenting opinions, shall be admissible in evidence at trial upon the offer of any party, if the court conducts a review of the arbitration decision and any other relevant information submitted by the parties and concludes that:

(1) the findings of fact by the arbitration board were not clearly erroneous;

(2) the decision is in accordance with applicable law;

(3) the procedures required for conducting the hearing and rendering the decision were followed fairly and properly without prejudice to any party;

(4) any party who has not offered the arbitration decision in evidence may subpoena any member of the arbitration board for purposes of cross-examination.

Sec. 09.55.536. VOLUNTARY ARBITRATION. (a) A patient and any health care provider may execute an agreement to submit to arbitration any dispute, controversy, or issue arising out of care of treatment by the health care provider during the period that the agreement is in force or that has already arisen between the parties.

(b) An agreement to arbitrate executed before care or treatment is provided between a patient and health care provider shall clearly provide in bold print on the face of the agreement that execution of the agreement by the patient is not a prerequisite to receiving care or treatment. If this subsection is not complied with by the health care provider, the agreement to arbitrate is void. The form to be used

shall be approved in advance by the director of insurance to assure it fairly informs the patient and properly protects his interests.

(c) Each admission to a hospital shall be treated as separate and distinct for the purposes of an agreement to arbitrate, but a person receiving outpatient care from a hospital or clinic or a member of a health maintenance organization may execute an agreement with the hospital which provides for continuation of the agreement for a continuing program of treatment or during continued membership.

(d) Arbitration shall take place under the same procedures prescribed for mandatory arbitration under sec. 536 of this chapter unless the parties agree otherwise in accordance with general guidelines promulgated as regulations by the director of insurance to assure fairness to the parties.

(e) Reasonable compensation based on the extent and duration of services rendered shall be paid to members of the arbitration board by the court as well as the costs of experts required by the board.

Sec. 09.55.537. ALTERNATIVE TO ARBITRATION. (a) If arbitration under sec. 535 of this chapter is waived by all the parties, and as an alternative to arbitration, the court shall appoint an expert advisory panel to advise the fact finder on the medical facts of the case unless the court decides that an expert advisory opinion is not necessary for a decision in the case. The court shall, by order, determine professions or specialties to be represented on the expert advisory panel and shall advise each party of the professions or specialties to be represented, giving the parties the opportunity to object or make suggestions.

(b) The expert advisory panel may compel the attendance of witnesses, physically or orally examine the parties, consult with specialists or learned works they consider appropriate, and compel the produc-

tion of, and examine all relevant hospital, medical, or other records relating to health care treatment. The panel may meet in camera, but shall maintain a record of any testimony or oral statements of witnesses, and shall maintain copies of any written statements or opinions that it receives.

(c) Not less than 30 days after selection of the panel, it shall make a written report to the parties and the court answering any questions put to it by the court on medical questions. The report shall include copies of all written statements, opinions, or records relied on by the panel, and either a transcription or other record of any oral statements or opinions; the report shall specify any medical or scientific authority relied upon and shall include the results of any physical or mental examination performed on the plaintiff. Each member shall sign the report and his signature constitutes his adoption of all statements and opinions contained in it; however, a member may, instead of signing the report, submit a concurring or dissenting report which complies with the requirements of this subsection. A member may not attest to any portion of the report as to which he is not qualified to give expert testimony.

(d) The report of the panel and any dissenting or concurring opinion are admissible in evidence to the same extent, and have the same force and effect, as though its contents were orally testified to by the person or persons preparing it. The court shall delete any portion that would not be admissible because of lack of foundation for opinion testimony, or otherwise. Either party may submit expert testimony to support or refute the report. The jury shall be instructed in general terms that the report shall be considered and evaluated in the same manner as any other expert testimony. Any member of the panel may be called by any party and may be cross-examined as to the contents of

the report or of his dissenting or concurring opinion.

(e) Members of a panel are entitled to travel expenses and per diem in accordance with state law pertaining to members of boards and commissions for all time spent in preparing its report and matters incidental to it, which shall be paid by the court. If a panel member is called upon as a witness at trial or upon deposition, he is entitled to payment of an expert witness fee. In any case in which the court determines that a party has made a patently frivolous claim or a patently frivolous denial of liability, it shall order that all costs of the expert advisory panel be borne by the party making that claim or denial.

(f) Parties to the case, and counsel, may not communicate out of court with members of the panel on the subject matter of its inquiry and report, or cause or solicit others to do so, except through ordinary discovery proceedings.

* Sec. 32. AS 09.55.540 is amended to read:

Sec. 09.55.540. BURDEN OF PROOF. (a) In a malpractice action based on the negligence or wilful misconduct of a health care provider [PHYSICIAN LICENSED UNDER AS 08.64, OR A DENTIST LICENSED UNDER AS 08.36], the plaintiff has [SHALL HAVE] the burden of proving by a preponderance of the evidence

(1) the degree of knowledge or skill possessed or the degree of care ordinarily exercised under the circumstances, at the time of the act complained of, by health care providers in the field or specialty in which the defendant is practicing [BY PHYSICIANS OR DENTISTS PRACTICING THE SAME SPECIALTY IN SIMILAR COMMUNITIES TO THAT IN WHICH THE DEFENDANT PRACTICES];

(2) that the defendant either lacked this degree of knowledge or skill or failed to exercise this degree of care; and

(3) that as a proximate result of this lack of knowledge or skill or the failure to exercise this degree of care the plaintiff suffered injuries that would not otherwise have been incurred.

(b) In malpractice actions there is [SHALL BE] no presumption of negligence on the part of the defendant.

* Sec. 33. AS 09.55 is amended by adding new sections to read:

Sec. 09.55.546. ADVANCE PAYMENTS. In an action to recover damages under secs. 530 - 560 of this chapter, no advance payment made by the defendant health care provider or his professional liability insurer to or on behalf of the plaintiff may be admissible as evidence or may be construed as an admission of liability for injuries or damages suffered by the plaintiff; however, a final award in favor of the plaintiff shall be reduced to the extent of any advance payment. The advance payment shall inure to the exclusive benefit of the defendant or the insurer making the payment.

Sec. 09.55.547. AD DAMNUM. In a cause of action against a health care provider for malpractice, the complaint or any other pleadings may not contain an ad damnum clause or monetary amount claimed against the defendant health care provider, except as necessary for jurisdictional purposes.

regarding awards and collateral sources
The provisions in the House and Senate bills differ in drafting and mechanics

Sec. 09.55.548. AWARDS, COLLATERAL SOURCE. (a) Damages shall be awarded in accordance with principles of the ~~com~~ common law, except that the fact finder in a malpractice action shall render an award as to damages by category of loss, stating all damages by category of loss in dollars per month and for a certain number of months or if the fact finder finds a permanent disablement, for the life of the plaintiff. The court may enter a judgment that future damages be paid in whole or in part by periodic payments rather than by a lump-sum payment; the judgment shall include, if necessary, other provisions to assure that funds will be available as periodic payments become due. In this subsection, future damages includes damages for future medical treatment, care or custody, loss of future earnings, or loss of bodily function of the claimant.

(b) Except when the collateral source is a federal program which by law must seek subrogation and except death benefits paid under life insurance, a claimant may only recover damages from the defendant which exceed amounts received by the claimant as compensation for his injuries from collateral sources, whether private, group or governmental, and whether contributory or noncontributory. The court shall offset collateral sources, other than a federal program which must by law seek subrogation and the death benefit paid under life insurance, after the fact finder has rendered an award, but the court shall also take into account the value of claimant's rights to coverage exhausted or depleted by payment of these collateral benefits. It may do so by adding back a reasonable estimate of their probable value, or by earmarking and holding for possible periodic payment under (a) of this section that amount of the award that would otherwise have been deducted, to see if the impairment of claimant's rights actually takes place in the future.

* Sec. 34. AS 09.55.550 is amended to read:

Sec. 09.55.550. JURY INSTRUCTIONS. In health care [MEDICAL]

malpractice actions the jury shall be instructed that the plaintiff has the burden of proving [, BY A PREPONDERANCE OF THE EVIDENCE,] the health care provider's negligence or wilful misconduct in accordance with the standard of proof specified in sec. 540 of this chapter [OF THE PHYSICIAN OR DENTIST]. The jury shall be further instructed that injury alone does not raise a presumption of the health care provider's [PHYSICIAN'S OR DENTIST'S] negligence or misconduct.

The House bill provides that no cause of action may arise against a health care provider for breach of a ~~[illegible]~~ an oral contract to provide a specific cure or result.

* Sec. 35. AS 09.55 is amended by adding new sections to read:

Sec. 09.55.556. INFORMED CONSENT. (a) A health care provider is liable for failure to obtain the informed consent of a patient if the claimant establishes by a preponderance of the evidence that the provider has failed to inform the patient of the common risks and reasonable alternatives to the proposed treatment or procedure, and that but for that failure the claimant would not have consented to the proposed treatment or procedure.

(b) It is a defense to any action for health care malpractice based upon an alleged failure to obtain informed consent that

(1) the risk not disclosed is too commonly known or is too remote to require disclosure;

(2) the patient stated to the health care provider that he

would undergo the treatment or procedure regardless of the risk involved or that he did not want to be informed of the matters to which he would be entitled to be informed;

(3) under the circumstances consent by or on behalf of the patient was not possible; or

(4) the health care provider after considering all of the attendant facts and circumstances used reasonable discretion as to the manner and extent to which the alternatives or risks were disclosed to the patient because he reasonably believed that a full disclosure would have a substantially adverse effect on the patient's condition.

Sec. 09.55.560. DEFINITIONS. In secs. 530 - 560 of this chapter "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital.

* Sec. 36. AS 09.65.090 is repealed and re-enacted to read:

Sec. 09.65.090. CIVIL LIABILITY FOR EMERGENCY AID. (a) A person at a hospital or at any other location, who renders emergency care or emergency counseling to an injured, ill, or emotionally distraught person who reasonably appears to the person rendering the aid to be in immediate need of emergency aid in order to avoid serious harm or death is not liable for civil damages as a result of an act or omission in rendering emergency aid.

(b) This section does not preclude liability for civil damages as

a result of gross negligence or reckless or intentional misconduct.

the FCC held off on deciding whether to include hospitals in the corporation,

* Sec. 37. AS 18.20 is amended by adding a new section to read:

Sec. 18.20.045. INSURANCE REQUIRED. (a) Every hospital, as a condition of licensure, shall maintain and submit to the department evidence of insurance against liability to inpatients and outpatients for malpractice issued by the Health Care Providers Indemnity Corporation, in amounts of not less than $200,000 per occurrence, and an aggregate liability per year of $1,000,000 minimum, and an additional $20,000 for each bed over 50.

(b) The director of insurance or his designee shall waive the requirement in (a) of this section for a hospital if the hospital furnishes satisfactory evidence of having other insurance providing coverage in amounts not less than those specified in (a) of this section. No waiver granted under this subsection may extend beyond the normal expiration date of the hospital's insurance policy or January 1, 1977, whichever occurs first.

Sec. 18.20.075. RISK MANAGEMENT. (a) To be eligible for a license each hospital shall have in operation an internal risk management program which shall

(1) investigate the frequency and causes of adverse incidents in hospitals which cause injury to patients;

(2) develop and implement measures to minimize the risk of injury to patients from adverse incidents; in developing these measures each hospital shall take into account recommendations of its medical staff, the Health Care Providers Indemnity Corporation and private underwriters, industry standards, experience of other hospitals, and recommendations of licensing boards of other health care providers; and

(3) analyze patient grievances which relate to patient care.

(b) The department shall adopt by regulation and submit to the legislative administrative regulation review committee prior to implementation standards for risk management programs in hospitals in the state which may vary according to the size of the hospital, the type of care offered by the hospital, and other factors found relevant by the department.

* Sec. 38. AS 18 is amended by adding a new chapter to read:

CHAPTER 23. HEALTH CARE SERVICES INFORMATION.

Sec. 18.23.010. LIMITATION ON LIABILITY FOR PERSONS PROVIDING INFORMATION TO REVIEW ORGANIZATION. (a) No person providing information to a review organization is subject to action for damages or other relief by reason of having furnished that information, unless the information is false and the person providing the information knew or had reason to know the information was false.

(b) No privilege of confidentiality arising from a physician-patient relationship may be invoked to withhold pertinent information from review by a review organization.

Sec. 18.23.020. LIMITATION ON LIABILITY FOR MEMBERS OF REVIEW ORGANIZATIONS. No person who is a member or employee of, or who acts in an advisory capacity to, or who furnishes counsel or services to a review organization is liable for damages or other relief in an action brought by another whose activities have been or are being scrutinized

or reviewed by a review organization, by reason of the performance of a duty, function or activity of the review organization, unless the performance of the duty, function or activity was motivated by malice toward the affected person. No person is liable for damages or other relief in an action by reason of his performance of a duty, function, or activity as a member of a review organization or by reason of a recommendation or action of the review organization when the person acts in the reasonable belief that the action or recommendation is warranted by facts known to the person or to the review organization after reasonable efforts to ascertain the facts upon which the review organization's action or recommendation is made.

Sec. 18.23.030. CONFIDENTIALITY OF RECORDS OF REVIEW ORGANIZATION. (a) Except as provided in (b) of this section, all data and information acquired by a review organization, in the exercise of its duties and functions, shall be held in confidence and may not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review organization, and is not subject to subpoena or discovery. Except as provided in (b) of this section, no person described in sec. 20 of this chapter may disclose what transpired at a meeting of a review organization except to the extent necessary to carry out one or more of the purposes of a review organization, and the proceedings and records of a review organization are not subject to discovery or introduction into evidence in a civil action against a health care provider arising out of the matter which is the subject of consideration by the review organization. Information, documents, or records otherwise available from original sources are not immune from discovery or use in a civil action merely because they were presented during proceedings of a review organization, nor may a person who testified before a review organization or who is a member of it be prevented from testifying as to

matters within his knowledge, but a witness may not be asked about his testimony before a review organization or opinions formed by him as a result of its hearings, except as provided in (b) of this section.

(b) Testimony, documents, proceedings, records, and other evidence adduced before a review organization that are otherwise inaccessible under this section may be obtained by a health care provider who claims that denial is unreasonable, or may be obtained under subpoena or discovery proceedings brought by a plaintiff who claims that information provided to a review organization was false and claims that the person providing the information knew or had reason to know the information was false.

(c) Nothing in this chapter prevents a person whose conduct or competence has been reviewed under this chapter from obtaining, for the purpose of appellate review of the action of the review organization, any testimony, documents, proceedings, records and other evidence adduced before the review organization.

Sec. 18.23.040. PENALTY FOR VIOLATION. Other than as authorized by sec. 30 of this chapter, a disclosure of data and information acquired by a review committee or of what transpired at a review meeting is a misdemeanor and punishable under AS 11.05.010.

Sec. 18.23.050. PROTECTION OF PATIENT. Nothing in this chapter relieves a person of liability which he has incurred or may incur to a person as a result of furnishing health care to the patient.

Sec. 18.23.060. PARTIES BOUND BY REVIEW. When a review organization reviews matters under sec. 70(5)(H) of this chapter no party is bound by a ruling of the organization in a controversy, dispute or question unless he agrees in advance, either specifically or generally, to be bound by the ruling.

Sec. 18.23.070. DEFINITIONS. In this chapter, unless the context

otherwise requires,

(1) "administrative staf " means the staff of a hospital or clinic;

(2) "health care" means professional services rendered by a health care provider or an employee of a health care provider, and services furnished by a sanatorium, rest home, nursing home, boarding home or other institution for the hospitalization or care of human beings;

(3) "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.-72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital;

(4) "professional service" means service rendered by a health care provider of the type he is licensed to render;

(5) "review organization" means a hospital governing body or a committee whose membership is limited to health care providers and administrative staff, except where otherwise provided for by state or federal law, and which is established by a hospital, by a clinic, by one or more state or local associations of health care providers, by an organization of health care providers from a particular area or medical institution, or by a professional standards review organization established under 42 U.S.C., sec. 1320c-1 et seq., to gather and review information relating to the care and treatment of patients for the purposes of

(A) evaluating and improving the quality of health care rendered in the area or medical institution;

(B) reducing morbidity or mortality;

(C) obtaining and disseminating statistics and information relative to the treatment and prevention of diseases, illness and injuries;

(D) developing and publishing guidelines showing the norms of health care in the area or medical institution;

(E) developing and publishing guidelines designed to keep the cost of health care within reasonable bounds;

(F) reviewing the quality or cost of health care services provided to enrollees of health maintenance organizations;

(G) acting as a professional standards review organization under 42 U.S.C., sec. 1320c-1 et seq.;

(H) reviewing, ruling on, or advising on controversies, disputes or questions between

(i) a health insurance carrier or health maintenance organization and one or more of its insured or enrollees;

(ii) a professional licensing board, acting under its powers of discipline or license revocation or suspension, and a health care provider licensed by it when the matter is referred to a review organization by the professional licensing board;

(iii) a health care provider and his patients concerning diagnosis, treatment or care, or a charge or fee;

(iv) a health care provider and a health insurance carrier or health maintenance organization concerning a charge or fee for health care services provided to an insured or

enrollee; or

(v) a health care provider or his patients and the federal or a state or local government, or an agency of the federal or a state or local government;

(I) acting on the recommendation of a credential review committee or a grievance committee.

The insurance structures in the House and Senate bills vary substantially, as the Senate version is now before the committee, as included here

* Sec. 39. AS 21 is amended by adding a new chapter to read:

CHAPTER 88. HEALTH CARE PROVIDERS INSURANCE.

ARTICLE 1. PURPOSE.

Sec. 21.88.010. PURPOSE OF CHAPTER. It is the purpose of this chapter to provide a means of furnishing health care providers with adequate insurance against liability for medical negligence by concentrating all such insurance in one entity which can negotiate more successfully for insurance from casualty insurers and to distribute equitably the true cost of the insurance among the health care providers

insured.

ARTICLE 2. INDEMNITY CORPORATION.

Sec. 21.88.020. CORPORATION CREATED. There is created the Alaska Health Care Providers Indemnity Corporation which is a public corporation having a legal existence independent of and separate from the state. Obligations issued by the corporation do not constitute a debt, liability or obligation of the state or a pledge of full faith and credit of the state.

Sec. 21.88.030. CORPORATION BOARD OF GOVERNORS. (a) The corporation shall exercise its powers through a board of governors which shall be appointed by the governor of the state and confirmed by the legislature as provided in (b) of this section.

(b) The appointments to the board of governors shall be Alaska residents as follows:

(1) two physicians licensed in the state; one of the physicians shall be engaged in group practice in a clinic of six or more physicians;

(2) one person employed by a hospital or on the board of directors of a hospital;

(3) two professionals in the insurance field;

(4) two persons who are not health care providers or financially interested in the field of health care, attorneys, or representatives of the insurance industry.

(c) The term of office of each governor is three years, except that the governor of the state shall designate two initially appointed governors to serve for one year and two initially appointed governors to serve for two years.

(d) Upon the expiration of the term of a governor, the governor of the state shall appoint a successor who shall be from the same class

described in (b) of this section as the governor whose term has expired.

(e) Upon a governor's early resignation, death or inability to serve, the governor of the state shall appoint a successor from the same class defined in (b) of this section as the terminating governor, who shall serve for the unexpired term.

(f) The director or his designee is not a voting member of the board of governors but shall be notified by the board of and have the right to attend and participate in all meetings and proceedings of the board.

(g) Members of the board of governors receive compensation from the corporation of $100 per day when the board meets and necessary travel expenses.

Sec. 21.88.040. CORPORATION PLAN OF OPERATION. (a) Within 30 days after the effective date of this chapter, the board of governors shall prepare and submit to the director for approval a plan of operation which provides for the fair, reasonable and equitable administration of the affairs of the corporation and the discharge of the purposes for which it is created. The plan and any amendments of it become effective upon the director's approval. If the board of governors fails to submit a plan of operation, or if at a subsequent time the board of governors fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate a plan of operation or amendments which are necessary or advisable to effectuate the provisions of this chapter. Adoption of the plan is not subject to the Administrative Procedure Act (AS 44.62).

(b) The plan of operation shall

(1) establish the procedures by which all the powers and duties of the corporation specified in sec. 50 of this chapter shall

be performed;

(2) establish procedures for handling assets and discharging liabilities of the corporation;

(3) establish regular places and times for meetings of the board of governors;

(4) establish procedures for records to be kept of all financial transactions of the corporation, its agents, and the board of governors;

(5) establish the procedures for awarding contracts to indemnify or defend or to provide other services and to compensate the indemnitors or vendors;

(6) establish the procedures for issuing contracts of insurance as provided in sec. 50 of this chapter and for the determination of rates;

(7) contain additional provisions necessary or proper for the execution of the powers and duties of the corporation.

Sec. 21.88.050. POWERS AND DUTIES OF THE CORPORATION. (a) The corporation shall

(1) in the form approved by the director, issue to all health care providers who pay the premiums for it a contract or contracts indemnifying the health care provider and his employees who are health care providers against loss by reason of liability for professional services on an occurrence basis and agreeing to tender on behalf of the health care provider and his employees who are health care providers a defense in a proceeding brought under AS 09.55.530 - 09.55.560; the limit of liability shall be no less than the minimum liability coverage requirements to be maintained under AS 08.64.215 and AS 18.20.045; the contract shall cover the defense against but need not indemnify a claim for punitive damages; at the option of the health

care provider and for an additional premium the contract may cover claims against the health care provider that arise out of professional services performed by the health care provider after December 31, 1974 except that coverage will not be provided for a claim already filed or of which the health care provider had or reasonably should have had notice at the time the retroactive insurance was purchased;

(2) charge a premium for the protection provided by the contracts issued under (1) of this subsection which shall be determined by the board of governors in accordance with sec. 80 of this chapter and subject to the approval of the director;

The House bill does not require the corporation to obtain reinsurance for the policies it writes

(3) negotiate for and procure reinsurance from a casualty insurers or reinsurers for all of its liability incurred by contracts issued under (1) of this subsection; the corporation may not incur or retain under those contracts liability which is not reinsured as provided in this paragraph; if, after the exercise of due diligence, no reinsurance for all or a portion of the risk can be procured at reasonable rates from casualty insurers or reinsurers, the corporation through the board of governors, shall so certify to the director reinsurance shall then be provided by the Health Care Joint Underwriting Association as provided in sec. 110 et seq. of this chapter for that

portion not reinsured by a private carrier;

(4) comply with or be subject to AS 21.06.090; 21.06.120; 21.06.140; 21.06.160; 21.06.250; AS 21.09.180; 21.09.190; 21.09.200; 21.09.250; 21.09.280; AS 21.12.020(b), (c), (d), and (e); and chs. 18, 21, 24, and 36 of this title;

(5) carry out the obligations of the contracts issued under (1) of this subsection by defending all covered claims made against insured health care providers and by paying all liabilities which are finally adjudicated against the insured health care provider or which may in the opinion of the corporation reasonably be expected to be finally adjudicated against the health care provider to the extent of the contract obligation;

(6) provide coverage to health care providers for liability in excess of the minimum limits required for licensure as a health care provider, but limited to $1,000,000 for individual health care providers and $5,000,000 for hospitals, if there is a finding by the director that this coverage is unavailable at a reasonable cost and that this coverage can be made available at a reasonable cost through the corporation; if this paragraph is implemented, then each health care provider obtaining excess coverage up to these amounts shall obtain it from the corporation.

(b) The corporation may

See Hamilton, [illegible] other than [illegible] tails, to [illegible] corporation [illegible] available on the private market and to [illegible] services results, [illegible]

from the Senate approach because the corporation must assure those providers about whom such a finding has been made

(1) in the form approved by the director, issue contracts of professional liability insurance to chiropractors licensed under AS 08.-20, dental hygienists licensed under AS 08.32, dentists licensed under AS 08.36, nurses licensed under AS 08.68, dispensing opticians licensed under AS 08.71, optometrists licensed under AS 08.72, pharmacists licensed under AS 08.80, physical therapists licensed under AS 08.84, and pyschologists and psychological associates licensed under AS 08.86;

(2) employ or retain persons, individual or corporate, to discharge its obligations and pay reasonable compensation for those services; employees of the corporation are not considered state employees;

(3) provide coverage to health care providers for other hazards where there is a finding by the director that this coverage is otherwise unavailable by reason of the operation of the corporation;

(4) borrow or advance funds necessary to effectuate the purposes of the corporation;

(5) negotiate and become a party to those contracts as are necessary to carry out the purposes of the corporation;

(6) sue or be sued in the name of the corporation;

(7) provide risk management advice and services to hospitals;

(8) perform all other acts necessary and proper to effectuate the corporation.

The House bill does not impose a premium tax on the corporation

Sec. 21.88.060. PREMIUM TAX. The corporation shall pay a premium tax in the amount of one and one-half per cent of the total direct premium income received by the corporation during the year ending on the preceding December 31, after deducting the applicable cancellations, returned premium, the unabsorbed portion of any deposit premiums, all policy dividends, unabsorbed premiums refunded to policyholders, refunds, savings, savings coupons and other similar returns paid or credited to policyholders with respect to their policies. The tax shall be paid to the director annually before April 1 of each year.

Sec. 21.88.070. STATISTICS. The corporation shall collect, maintain and report information concerning claims against health care providers. The information shall be on forms prescribed by the director, and shall be sufficient to enable a proper determination of losses for rate making and to identify causes and sources of loss for loss control. At least annually the corporation shall report to the director the number and amount of claims filed, reserved, paid, settled and adjudicated during the year, the premiums paid to and the expenses incurred by the corporation during the year. This report shall be available to the public. The director may require that supplemental reports include the names of insured health care providers and the claimants; however, no reports which become publicly available may include the names of health care providers or claimants or information that will permit by inference the identity of specific health care providers or claimants. All statistics shall be made available to the appropriate licensing board or agency.

Sec. 21.88.080. RATES. (a) The rates and rating plans used by the corporation for the policies issued shall be determined by license category of health care providers in accordance with all of the following:

(1) rates for physicians shall be set as a function of the physician's medical revenue;

(2) rates for hospitals shall be set as a function of the number of permanent beds in the hospital;

(3) a minimum rate may be set for each category of health care provider or discipline or classification within the license category;

(4) rates may not be excessive; rates are excessive if, after a period of time and with respect to an amount of gross premium which are actuarially credible, the premiums exceed losses incurred by the corporation, including losses paid, reserves for claims reported and unpaid, reserves for claims incurred during the policy period and not reported, provided that reserves for claims incurred during the policy period and reasonably expected to be reported after three years after the incident may be included on a different basis due to the additional financial flexibility provided by the corporation, and reasonable expenses for the operation of the corporation;

(5) rates shall not be inadequate; rates are inadequate if, based on available actuarial data, the premiums to be paid by the health care providers are or may reasonably be expected to be insufficient to pay for losses incurred by the corporation, including claims paid, reserves for claims reported and unpaid, reserves for claims incurred during the policy period and not reported provided that reserves for claims incurred during the policy period and reasonably expected to be reported after three years after the incident may be included on a different basis due to the additional financial flexibility provided by the corporation, and reasonable expenses for the operation of the corporation;

(6) rates may not be unfairly discriminatory;

(7) rates shall be adjusted annually;

(8) rates for any policy year shall be calculated to include the adjustment for actual experience of the corporation;

(9) in considering losses to be incurred, changes in the law, national, regional or local trends in medical negligence awards, and other relevant factors may be considered;

(10) income from the investment of reserves shall be considered;

(11) individual risk underwriting factors shall be considered.

The House bill requires that descriptions and classifications within license categories be considered in rate making, and that repayment of loan obligations be considered in rate making

(b) The standards in (a) of this section shall be applied to the policy terms the corporation decides to write.

Sec. 21.88.090. REQUIRED INSURANCE; CANCELLATION. The corporation shall provide insurance to all health care providers otherwise eligible for licensure under AS 08.64 and AS 18.20. The corporation may provide for installment payment of premiums in which event each installment is due by the date specified. The corporation may cancel any of its policies in the event of nonpayment of any premium or installment on a premium, or other charge, by mailing or delivering to the insured at the address shown on the policy and to the agency of the state issuing the insured's license written notice stating when, not less than 10 days

after notice is received by the insured, the cancellation is effective.

The House bill contains no JUA.

ARTICLE 3. JOINT UNDERWRITING ASSOCIATION.

Sec. 21.88.110. ASSOCIATION CREATED. (a) The Health Care Providers Joint Underwriting Association is created consisting of all licensed

(1) health care service corporations as defined in AS 21.-87.330;

(2) disability insurers as defined in AS 21.12.050;

(3) property insurers as defined in AS 21.12.060; and

(4) casualty insurers as defined in AS 21.12.070.

(b) Every insurer described in (a) of this section shall be a member of the association and shall remain a member as a condition of its authority to continue to transact that kind of business in this state; except that any disability insurer may elect to pay any tax or assessments due without otherwise participating as a member.

(c) The association shall commence operation upon a finding by the director, after public hearing, that after the exercise of due diligence no reinsurance could be procured at reasonable rates by the corporation from a casualty insurer or reinsurer. After the association has commenced operation, if the director determines, after public

hearing, that health care malpractice insurance is available through insurers licensed in this state with respect to which he has previously made the former finding, the association shall cease its underwriting operations. At any time, after notice and hearing, the director may, upon a finding that it is no longer needed, terminate the operation of the association.

Sec. 21.88.120. PURPOSE. The purpose of the association is to provide a market for medical malpractice insurance to the corporation on a self-supporting basis without subsidy from association members.

Sec. 21.88.130. ASSOCIATION BOARD OF DIRECTORS; TERM. The association shall be governed by a board of directors appointed by the governor of the state and consisting of two representatives of domestic casualty and property insurers, one representative of admitted disability insurers, one representative of health care service corporations, one representative of foreign casualty and property insurers, and two persons from the public. Members of the board of directors serve three-year terms.

Sec. 21.88.140. ASSOCIATION PLAN OF OPERATION. (a) Within 30 days after the association's creation the board of directors shall prepare and submit to the director for his approval a plan of operation which provides for the fair, reasonable and equitable administration of the affairs of the association and the discharge of the purposes for which it is created. The plan and any amendments of it become effective upon the director's approval. If the board of directors has failed to submit a plan of operation, or if at any subsequent time the board of directors fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate a plan of operation or amendments which are necessary or advisable to effectuate the provisions of this chapter. Adoption of the plan is not subject to the

Administrative Procedure Act (AS 44.62).

(b) The plan of operation shall

(1) establish the procedures for carrying out the powers and duties of the association specified in sec. 150 of this chapter;

(2) establish procedures for handling assets and discharging liabilities of the association;

(3) establish regular places and times for meetings of the board of directors;

(4) establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(5) establish the amount and method of reimbursing members of the board of directors;

(6) establish the procedures for awarding contracts to indemnify or defend or to provide other services and to compensate the indemnitors or vendors;

(7) establish the procedures for issuing contracts of insurance as provided in sec. 150 of this chapter and for the determination of rates;

(8) contain additional provisions necessary or proper for the execution of the powers and duties of the association.

Sec. 21.88.150. POWERS AND DUTIES OF THE ASSOCIATION. (a) The association shall

(1) provide reinsurance to the corporation covering contracts issued by the corporation indemnifying health care providers and their employees who are health care providers against loss by reason of liability for professional services and agreeing to tender on behalf of the health care providers and their employees who are health care providers a defense in an action brought under AS 09.55.530 - 09.55.560;

the limit of liability shall be no less than the minimum liability required to be indemnified as provided in AS 08.64.215 and AS 18.20.045, and the coverage shall be the same as that which the Health Care Providers Indemnity Corporation is required to provide under sec. 50 of this chapter;

(2) charge a premium for the protection provided by the contracts issued under sec. 50 of this chapter which shall be determined by the board of directors in accordance with sec. 80 of this chapter and subject to the approval of the director;

(3) comply with or be subject to AS 21.06.090; 21.06.120; 21.06.140; 21.06.160; 21.06.250; AS 21.09.180; 21.09.200; 21.09.250; 21.09.280; AS 21.12.020(b), (c), (d), and (e); and chs. 18, 21, 24, and 36 of this title;

(4) carry out the obligations of the contracts issued under sec. 50 of this chapter by defending all covered claims made against insured health care providers and paying all liabilities which are finally adjudicated against the insured health care provider or which may in the opinion of the association reasonably be expected to be finally adjudicated against the health care provider to the extent of the contract obligation.

(b) The association may

(1) employ or retain persons, individual or corporate, to discharge its obligations and pay reasonable compensation for those services;

(2) provide reinsurance to the corporation for coverage to health care providers for other hazards where there is a finding by the director that this coverage is otherwise unavailable by reason of the operation of the corporation;

(3) provide reinsurance to the corporation for coverage to

health care providers for liability under AS 09.55.530 - 09.55.560 in excess of the minimum limits required for licensure as a health care provider where there is a finding by the director that this coverage is unavailable at a reasonable cost and that this coverage can be made available at a reasonable cost through the corporation;

(4) provide reinsurance to the corporation for coverage for liability under AS 09.55.530 - 09.55.560 to chiropractors licensed under AS 08.20, dental hygienists licensed under AS 08.32, dentists licensed under AS 08.36, nurses licensed under AS 08.68, dispensing opticians licensed under AS 08.71, optometrists licensed under AS 08.72, pharmacists licensed under AS 08.80, physical therapists licensed under AS 08.84, and psychologists and psychological associates licensed under AS 08.86;

(5) borrow or advance funds necessary to effectuate the purposes of this association;

(6) negotiate and become a party to those contracts which are necessary to carry out the purposes of the association;

(7) sue or be sued in the name of the association;

(8) cede or assume reinsurance;

(9) perform all other acts necessary and proper to effectuate the association.

Sec. 21.88.160. RATES AND RATING PLANS. The rates and rating plans shall be determined as provided in sec. 80 of this chapter, except that allowance may not be made for profit to an indemnifying carrier or for income from investment of member-contributed funds; and provided that reserves for claims incurred during the policy period and reasonably expected to be reported after three years after the incident may be included on a different basis due to the additional financial flexibility provided by the association.

Sec. 21.88.170. ASSESSMENT. If sufficient funds are not available for the sound financial operation of the association, all members shall contribute to the financial requirements of the association by paying to the association an assessment to be determined by the board of governors of the association, these assessments to be prorated among all members in proportion to their direct written premiums or revenues in this state in the insurance lines the writing of which require membership in the association, in the two years ending on the preceding December 31, after deducting the applicable cancellations, returned premium, the unabsorbed portion of any deposit premium, all policy dividends, unabsorbed premiums refunded to policyholders, refunds, savings, savings coupons and other similar returns paid or credited to policyholders with respect to their policies. Any assessment under this section is a tax obligation in addition to taxes required under AS 21.09.210 and notwithstanding the provisions of AS 21.09.210(e).

Sec. 21.88.180. RATE ADJUSTMENT. (a) If in any year an assessment is made under sec. 170 of this chapter, rates for the next period shall be increased from the rate determined under sec. 160 of this chapter by an amount sufficient to reimburse all members the amounts assessed.

(b) No assessment may be reimbursed to members without prior approval of the director and no interest accrues in favor of members on amounts assessed.

(c) If, after establishing required reserves, there is an excess amount in reserve, the excess premium shall be refunded to the insured health care providers.

Sec. 21.88.190. REPORTS. At least annually the association shall report to the director concerning its affairs. The report shall be in the form prescribed by the director.

The House bill's loan fund differs from the loan fund in the Senate bill in that loans under the House version are made to the Corporation to maintain reserves, the interest rate is higher and the term is shorter.

ARTICLE 4. LOAN FUND.

Sec. 21.88.210. FUND ESTABLISHED. (a) There is in the Department of Commerce and Economic Development a medical malpractice liability revolving loan fund to be administered by the director of insurance.

(b) Loans shall be made from the fund to the Joint Underwriting Assoication upon certification by the director that a loan is necessary for the corporation to spread costs out over time because of fluctuations in loss experience. If a loan is made to the corporation from the fund, the Joint Underwriting Association shall issue a note to the fund pledging the premiums collected in the future as security for the loan.

(c) Loans from the fund shall be repaid by the Joint Underwriting Association within five years at an annual interest rate of six per cent.

(d) The director may sell at par value to the Department of Revenue the notes, security instruments and pledge agreements held by the Department of Commerce and Economic Development as security for loans made under this section. The Department of Revenue shall purchase all the notes offered until the current principal amount of the

notes purchased and held by the Department of Revenue equals $5,000,000.

ARTICLE 5. GENERAL PROVISIONS.

Sec. 21.88.900. DEFINITIONS. As used in this chapter,

(1) "association" means the Health Care Providers Joint Underwriting Association;

(2) "corporation" means the Health Care Providers Indemnity Corporation;

(3) "health care provider" means a physician licensed under AS 08.64 and a hospital licensed under AS 18.20.

* Sec. 40. AS 21.18.090 is amended by adding a new paragraph to read:

(5) reserves for the Joint Underwriting Association are to include claims reported and unpaid; reserves for claims incurred but not reported, but those which may reasonably be expected to be reported beyond three years after the date of occurrence may be included on a different basis due to the additional financial flexibility of the association.

* Sec. 41. AS 08.02 is amended by adding a new section to read:

Sec. 08.02.020. LIMITATION OF LIABILITY FOR MEMBERS OF LICENSING BOARDS. No person is liable for damages or other relief in an action by reason of his performance of a duty, function, or activity as a member of a licensing board or by reason of a recommendation or action of the board when the person acts in the reasonable belief that his action or recommendation is warranted by facts known to him or to the board after reasonable efforts to ascertain the facts upon which the action or recommendation is made.

* Sec. 42. AS 09.55.535, and AS 09.55.537, enacted in sec. 31 of this Act, have the effect of changing the Alaska Supreme Court's Rules of Civil Procedure by requiring the submission of medical malpractice claims against hospitals and physicians to either nonbinding arbitration or to expert

advisory panels, unless all parties to the action agree otherwise.

* Sec. 43. AS 08.64.365 and AS 08.68.040 are repealed.

* Sec. 44. This Act takes effect 30 days after enactment.

prop. sec. 1-5
4/11 Jones Draft

Sec. AS 09.55 is amended by adding new sections to read:

Sec. 09.55.535. VOLUNTARY ARBITRATION. (a) A patient and any health care provider may execute an agreement to submit to arbitration any dispute, controversy, or issue arising out of care or treatment by the health care provider during the period that the agreement is in force or that has already arisen between the parties.

(b) An agreement to arbitrate executed before care or treatment is provided [redacted] shall clearly provide in bold print on the face of the agreement that execution of the agreement by the patient is not a prerequisite to receiving care or treatment. If this subsection is not complied with by the health care provider, the agreement to arbitrate is void. The form to be used shall be approved in advance by the attorney general of the state to assure it fairly informs both parties to the agreement and properly protects their interests.

(c) The agreement shall provide that the person receiving health care may revoke the agreement within 60 days after execution by notifying the health care provider in writing. A health care provider may not revoke the agreement after its execution.

(d) Each admission to a hospital shall be treated as separate and distinct for the purposes of an agreement to arbitrate, but a person receiving outpatient care from a hospital or clinic or a member of a health maintenance organization may execute an agreement with the hospital which provides for continuation of the agreement for a continuing program of treatment or during continued membership.

(e) Upon the filing of a malpractice claim which is subject to an agreement to arbitrate, the claim shall be submitted to an arbitration panel. The arbitration panel shall consist of three arbitrators: one [illegible] selected by the plaintiff or plaintiffs, one arbitrator

designated by the defendant or defendants, and a third arbitrator designated by mutual agreement who shall serve as chairperson of the board. If the parties cannot agree on the third person, the court will provide a list of three or more persons who might serve as chairperson of the arbitration panel, which shall be furnished by the attorney general. Plaintiff or plaintiffs together and defendant or defendants together may each strike one or more names from the list, so after each side has done so at least one name remains on the list, providing a basis for the final selection by the court.

(f) The attorney general shall prepare a list of persons consisting of lawyers or other persons qualified to serve as chairperson of arbitration panels. They shall be selected on basis of their technical expertise, judicial temperament, and capability of impartially acting on malpractice claims. The attorney general shall submit a list of at least three names whenever requested to do so by the court along with detailed biographical information on each person listed.

(g) Each member of the panel shall receive reasonable compensation to be paid by the court based on the extent and duration of services rendered. The court shall also pay the costs of experts called by the panel.

(h) The [redacted] may appoint an expert advisory panel, with the powers of the expert advisory panel under sec. 536 of this chapter, to advise the [redacted] on the medical facts of the case.

(i) The court shall specify the shortest practical deadline for completion of the work of the arbitration panel, taking into account all the circumstance and the nature of the case.

(j) The provisions of the Uniform Arbitration Act, AS 09.43.010 - 09.43.180, apply to arbitrations under this section insofar as they are applicable and do not conflict with the provisions of this section;

arbitrations under this section shall be conducted in accordance with any rules of court which may be adopted.

Sec. 09.55.536. EXPERT ADVISORY PANEL. (a) In any action for damages due to personal injury or death based upon the provision of professional services by a health care provider, the court shall establish a three-person expert advisory panel in accordance with this section unless the court decides that an expert advisory opinion is not necessary for a decision in the case. When the action is filed the court shall, by order, determine the professions or specialties to be represented on the expert advisory panel and shall advise each party of the professions or specialties to be represented, giving the parties the opportunity to object or make suggestions.

(b) The expert advisory panel may compel the attendance of witnesses, interview the parties, physically examine the injured person if alive, consult with the specialists or learned works they consider appropriate, and compel the production of and examine all relevant hospital, medical, or other records or materials relating to the health care treatment. The panel may meet in camera, but shall maintain a record of any testimony or oral statements of witnesses, and shall keep copies of all written statements and opinions it receives.

(c) Not more than 30 days after selection of the panel, it shall make a written report to the parties and to the court, substantially answering the following questions in addition to any other question which the court puts to the panel:

(1) What was the medical complaint or condition for which the person sought or was brought to medical care?

(2) What would have been the likely course of the complaint or condition without medical care?

(3) Was the care appropriate?

(4) Did an injury arise from the medical care?

(5) What was the injury?

(6) What specifically caused the injury?

(7) Was the injury caused by negligence?

(8) Is the injury stable or will it improve or become worse?

(9) Is the outcome different than would be expected

(c) In any case in which the answer to one or more of the questions under (b) of this section depends upon the resolution of factual questions which are not the proper subject of expert opinion, the report shall so state and may answer questions based upon hypothetical facts that are fully and completely set out in the opinion. The report shall include copies of all written statements, opinions, or records relied upon by the panel and either a transcription or other record of any oral statements or opinions; shall specify any medical or scientific authority relied upon by the panel; and shall include the results of any physical or mental examination performed on the plaintiff. Each member shall sign the report and his signature constitutes his adoption of all statements and opinions contained in it; however, a member may, instead of signing the report, submit a concurring or dissenting report which complies with the requirements of this subsection, and a member may not attest to any portion of the report as to which he is not qualified to give expert testimony.

(d) The report of the panel and any dissenting or concurring opinion are admissible in evidence to the same extent as though its contents were orally testified to by the person or persons preparing it. The court shall delete any portion that would not be admissible because of lack of foundation for opinion testimony, or otherwise. Either party may submit expert testimony to support or refute the report. The jury shall be instructed in general terms that the report shall be considered and evaluated in the same manner as any other expert testimony. Any

member of the panel may be called by any party and may be cross-examined as to the contents of the report or of his dissenting or concurring opinion.

(e) No discovery may be undertaken in a case until the report of the expert advisory panel is received. However, the court may relax this prohibition upon a showing of good cause by any party. If the panel has not completed its report within the 30-day period prescribed in (b) of this section, the court may, upon application, grant it an additional 30 days.

(f) Members of a panel are entitled to travel expenses and per diem in accordance with state law pertaining to members of boards and commissions for all time spent in preparing its report and matters incidental to it. If a panel member is called upon as a witness at trial or upon deposition, he is entitled to payment of an expert witness fee. All expenses incurred by the panel shall be paid by the court. However, in any case in which the court determines that a party has made a patently frivolous claim or a patently frivolous denial of liability, it shall order that all costs of the expert advisory panel be borne by the party making that claim or denial.

(g) Parties to the case and their counsel may not initiate communication out of court with members of the panel on the subject matter of its inquiry and report or cause or solicit others to do so, except through ordinary discovery proceedings.

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Rough Draft

* Sec. 39. AS 21 is amended by adding a new chapter to read:

CHAPTER 88. HEALTH CARE PROVIDERS INSURANCE.

ARTICLE 1. PURPOSE.

Sec. 21.88.010. PURPOSE OF CHAPTER. It is the purpose of this chapter to provide a means of furnishing health care providers with adequate insurance against liability for medical negligence ~~by concentrating all such insurance in one entity which can negotiate more successfully for insurance from casualty insurers and to distribute equitably the true cost of the insurance among the health care providers insured~~.

ARTICLE 2. INDEMNITY CORPORATION.

Sec. 21.88.020. CORPORATION CREATED. There is created the Alaska Health Care Providers Indemnity Corporation which is a public corporation having a legal existence independent of and separate from the state. Obligations issued by the corporation do not constitute a debt, liability or obligation of the state or a pledge of full faith and credit of the state.

Sec. 21.88.030. CORPORATION BOARD OF GOVERNORS. (a) The corporation shall exercise its powers through a board of governors which shall be appointed by the governor of the state and confirmed by the legislature as provided in (b) of this section.

(b) The appointments to the board of governors shall be Alaska residents as follows:

(1) two physicians licensed in the state; one of the physicians shall be engaged in group practice in a clinic of six or more physicians;

(2) one person employed by a hospital or on the board of directors of a hospital;

(3) two professionals in the insurance field;

(4) two persons who are not health care providers or financially interested in the field of health care, attorneys, or representatives of the insurance industry.

(c) The term of office of each governor is three years, except that the governor of the state shall designate two initially appointed governors to serve for one year and two initially appointed governors to serve for two years.

(d) Upon the expiration of the term of a governor, the governor of the state shall appoint a successor who shall be from the same class described in (b) of this section as the governor whose term has expired.

(e) Upon a governor's early resignation, death or inability to serve, the governor of the state shall appoint a successor from the same class defined in (b) of this section as the terminating governor, who shall serve for the unexpired term.

(f) The director or his designee is not a voting member of the board of governors but shall be notified by the board of and have the right to attend and participate in all meetings and proceedings of the board.

(g) Members of the board of governors receive compensation from the corporation of $100 per day when the board meets and necessary travel expenses.

Sec. 21.88.040. CORPORATION PLAN OF OPERATION. (a) Within 30 days after the effective date of this chapter, the board of governors shall prepare and submit to the director for approval a plan of operation which provides for the fair, reasonable and equitable administration of the affairs of the corporation and the discharge of the purposes for which it is created. The plan and any amendments of it become effective upon the director's approval. If the board of governors fails to submit a plan of operation, or if at a subsequent time the board of governors

fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate a plan of operation or amendments which are necessary or advisable to effectuate the provisions of this chapter. Adoption of the plan is not subject to the Administrative Procedure Act (AS 44.62).

(b) The plan of operation shall

(1) establish the procedures by which all the powers and duties of the corporation specified in sec. 50 of this chapter shall be performed;

(2) establish procedures for handling assets and discharging liabilities of the corporation;

(3) establish regular places and times for meetings of the board of governors;

(4) establish procedures for records to be kept of all financial transactions of the corporation, its agents, and the board of governors;

(5) establish the procedures for awarding contracts to carry out the provisions of this chapter;

(6) establish the procedures for issuing contracts of insurance as provided in sec. 50 of this chapter and for the determination of rates;

(7) contain additional provisions necessary or proper for the execution of the powers and duties of the corporation.

Sec. 21.88.050. POWERS AND DUTIES OF THE CORPORATION. (a) The corporation shall

(1) in the form approved by the director, issue to all health care providers who pay the premiums for it a contract or contracts indemnifying the health care provider and his employees who are health care providers against loss by reason of liability for professional

services on an occurrence basis and agreeing to tender on behalf of the health care provider and his employees who are health care providers a defense in a proceeding brought under AS 09.55.530 - 09.55.560; the limit of liability shall be no less than the minimum liability coverage requirements to be maintained under AS 08.64.215 and AS 18.20.045; the contract shall cover the defense against but need not indemnify a claim for punitive damages; at the option of the health care provider and for an additional premium the contract may cover claims against the health care provider that arise out of professional services performed by the health care provider after December 31, 1974 except that coverage will not be provided for a claim already filed or of which the health care provider had or reasonably should have had notice at the time the retroactive insurance was purchased;

(2) charge a premium for the protection provided by the contracts issued under (1) of this subsection which shall be determined by the board of governors in accordance with sec. 80 of this chapter and subject to the approval of the director;

(3) comply with or be subject to AS 21.06.090; 21.06.120; 21.06.140; 21.06.160; 21.06.250; AS 21.09.130; 21.09.190; 21.09.200; 21.09.250; 21.09.280; AS 21.12.020(b), (c), (d), and (e); and chs. 18, 21, 24, and 36 of this title;

(4) carry out the obligations of the contracts issued under (1) of this subsection by defending all covered claims made against insured health care providers and by paying all liabilities which are finally adjudicated against the insured health care provider or which may in the opinion of the corporation reasonably be expected to be finally adjudicated against the health care provider to the extent of the contract obligation;

(5) provide coverage to health care providers for liability

in excess of the minimum limits required for licensure as a health care provider, but limited to $1,000,000 for individual health care providers and $5,000,000 for hospitals, if there is a finding by the director that this coverage is unavailable at a reasonable cost and that this coverage can be made available at a reasonable cost through the corporation; if this paragraph is implemented, then each health care provider obtaining excess coverage up to these amounts shall obtain it from the corporation, and the corporation may procure reinsurance for all risks incurred by contracts issued under this paragraph from the private market.

(b) The corporation may

(1) in the form approved by the director, issue contracts of professional liability insurance to chiropractors licensed under AS 08.20, dental hygienists licensed under AS 08.32, dentists licensed under AS 08.36, nurses licensed under AS 08.68, dispensing opticians licensed under AS 08.71, optometrists licensed under AS 08.72, pharmacists licensed under AS 08.80, physical therapists licensed under AS 08.84, and pyschologists and psychological associates licensed under AS 08.86;

(2) employ or retain persons, individual or corporate, to discharge its obligations and pay reasonable compensation for those services; employees of the corporation are not considered state employees;

(3) (4) recommend that the director hold public hearings for the purpose of commencing operation of the joint underwriting association established under secs. 110 - 190 of this chapter; if the joint underwriting association begins operation, the corporation may purchase reinsurance from the association for any of the liability incurred by

contracts issued by the corporation;

(4)~~(5)~~ provide coverage to health care providers for other hazards where there is a finding by the director that this coverage is otherwise unavailable by reason of the operation of the corporation;

(5)~~(6)~~ borrow or advance funds necessary to effectuate the purposes of the corporation;

(6)~~(7)~~ negotiate and become a party to those contracts as are necessary to carry out the purposes of the corporation;

(7)~~(8)~~ sue or be sued in the name of the corporation;

(8)~~(9)~~ provide risk management advice and services to hospitals;

(9)~~(10)~~ negotiate and become a party to contracts for management services for the corporation;

(10)~~(11)~~ perform all other acts necessary and proper to effectuate the corporation.

Sec. 21.88.060. PREMIUM TAX. The corporation shall pay a premium tax in the amount of one and one-half per cent of the total direct premium income received by the corporation during the year ending on the preceding December 31, after deducting the applicable cancellations, returned premium, the unabsorbed portion of any deposit premiums, all policy dividends, unabsorbed premiums refunded to policyholders, refunds, savings, savings coupons and other similar returns paid or credited to policyholders with respect to their policies. The tax shall be paid to the director annually before April 1 of each year.

Sec. 21.88.070. STATISTICS. The corporation shall collect, maintain and report information concerning claims against health care providers. The information shall be on forms prescribed by the director, and shall be sufficient to enable a proper determination of losses for rate making and to identify causes and sources of loss for loss control. At least annually the corporation shall report to the director

the number and amount of claims filed, reserved, paid, settled and adjudicated during the year, the premiums paid to and the expenses incurred by the corporation during the year. This report shall be available to the public. The director may require that supplemental reports include the names of insured health care providers and the claimants; however, no reports which become publicly available may include the names of health care providers or claimants or information that will permit by inference the identity of specific health care providers or claimants. All statistics shall be made available to the appropriate licensing board or agency.

Sec. 21.88.080. RATES. (a) The rates and rating plans used by the corporation for the policies issued shall be determined by license category of health care providers in accordance with all of the following:

(1) rates for physicians shall be set as a function of the physician's medical revenue;

(2) rates for hospitals shall be set as a function of the number of permanent beds in the hospital;

(3) rates may not be excessive; rates are excessive if, after a period of time and with respect to an amount of gross premium which are actuarially credible, the premiums exceed losses incurred by the corporation, including losses paid, reserves for claims reported and unpaid, reserves for claims incurred during the policy period and not reported, provided that reserves for claims incurred during the policy period and reasonably expected to be reported after three years after the incident may be included on a different basis due to the additional financial flexibility provided by the corporation, and reasonable expenses for the operation of the corporation;

(4) rates shall not be inadequate; rates are inadequate if,

based on available actuarial data, the premiums to be paid by the health care providers are or may reasonably be expected to be insufficient to pay for losses incurred by the corporation, including claims paid, reserves for claims reported and unpaid, reserves for claims incurred during the policy period and not reported provided that reserves for claims incurred during the policy period and reasonably expected to be reported after three years after the incident may be included on a different basis due to the additional financial flexibility provided by the corporation, and reasonable expenses for the operation of the corporation;

(5) rates may not be unfairly discriminatory;

(6) rates shall be adjusted annually;

(7) rates for any policy year shall be calculated to include the adjustment for actual experience of the corporation;

(8) in considering losses to be incurred, changes in the law, national, regional or local trends in medical negligence awards, and other relevant factors may be considered;

(9) income from the investment of reserves shall be considered;

(10) individual risk underwriting factors shall be considered;

(11) disciplines and classifications within the license categories of health care providers shall be considered.

(b) The standards in (a) of this section shall be applied to the policy terms the corporation decides to write.

Sec. 21.88.090. REQUIRED INSURANCE; CANCELLATION. The corporation shall provide insurance to all health care providers otherwise eligible for licensure under AS 08.64 and AS 18.20. The corporation may provide for installment payment of premiums in which event each installment is due by the date specified. The corporation may cancel any of its

policies in the event of nonpayment of any premium or installment on a premium, or other charge, by mailing or delivering to the insured at the address shown on the policy and to the agency of the state issuing the insured's license written notice stating when, not less than 10 days after notice is received by the insured, the cancellation is effective.

ARTICLE 3. JOINT UNDERWRITING ASSOCIATION.

Sec. 21.88.110. ASSOCIATION CREATED. (a) The Health Care Providers Joint Underwriting Association is created consisting of all licensed

(1) health care service corporations as defined in AS 21.-87.330;

(2) disability insurers as defined in AS 21.12.050;

(3) property insurers as defined in AS 21.12.060; and

(4) casualty insurers as defined in AS 21.12.070.

(b) Every insurer described in (a) of this section shall be a member of the association and shall remain a member as a condition of its authority to continue to transact that kind of business in this state, except that any disability insurer may elect to pay any tax or assessments due without otherwise participating as a member.

(c) The association shall commence operation if the director finds, after public hearing, that a market for reinsurance is needed by the corporation. After the association has commenced operation, if the director determines, after public hearing, that a market for reinsurance is no longer needed by the corporation, the association shall cease its underwriting operations.

Sec. 21.88.120. PURPOSE. The purpose of the association is to provide a market for medical malpractice reinsurance to the corporation on a self-supporting basis without subsidy from association members.

Sec. 21.88.130. ASSOCIATION BOARD OF DIRECTORS; TERM; COMPENSATION. The association shall be governed by a board of directors appointed by the governor of the state and consisting of two representatives of domestic casualty and property insurers, one representative of admitted disability insurers, one representative of health care service corporations, one representative of foreign casualty and property insurers, and two persons from the public. (b) Members of the board of directors serve three-year terms. (c) Board members receive compensation from the association at $100 per day spent at the board meets and reasonable expenses.

Sec. 21.88.140. ASSOCIATION PLAN OF OPERATION. (a) Within 30 days after the association's creation the board of directors shall prepare and submit to the director for his approval a plan of operation which provides for the fair, reasonable and equitable administration of the affairs of the association and the discharge of the purposes for which it is created. The plan and any amendments of it become effective upon the director's approval. If the board of directors has failed to submit a plan of operation, or if at any subsequent time the board of directors fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate a plan of operation or amendments which are necessary or advisable to effectuate the provisions of this chapter. Adoption of the plan is not subject to the Administrative Procedure Act (AS 44.62).

(b) The plan of operation shall

(1) establish the procedures for carrying out the powers and duties of the association specified in sec. 150 of this chapter;

(2) establish procedures for handling assets and discharging

liabilities of the association;

(3) establish regular places and times for meetings of the board of directors;

(4) establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(5) establish the procedures for awarding contracts to indemnify or defend or to provide other services and to compensate the indemnitors or vendors;

(6) establish the procedures for issuing contracts of insurance as provided in sec. 150 of this chapter and for the determination of rates;

(7) contain additional provisions necessary or proper for the execution of the powers and duties of the association.

Sec. 21.88.150. POWERS AND DUTIES OF THE ASSOCIATION. (a) The association shall

(1) provide reinsurance to the corporation covering contracts issued by the corporation for that portion of the liability incurred by the corporation it chooses to reinsure through the association, indemnifying health care providers and their employees who are health care providers against loss by reason of liability for professional services and agreeing to tender on behalf of the health care providers and their employees who are health care providers a defense in an action brought under AS 09.55.530 - 09.55.560;

(2) charge a premium for the protection provided by the reinsurance issued under (a)(1) of this section which shall be determined by the board of directors in accordance with sec. 80 of this chapter and subject to the approval of the director;

(3) comply with or be subject to AS 21.06.090; 21.06.120;

21.06.140; 21.06.160; 21.06.250; AS 21.09.180; 21.09.200; 21.09.250; 21.09.280; AS 21.12.020(b), (c), (d), and (e); and chs. 18, 21, 24, and 36 of this title;

(4) carry out the obligations of the contracts issued under (a)(1) of this section by defending all covered claims made against insured health care providers and paying all liabilities which are finally adjudicated against the insured health care provider or which may in the opinion of the association reasonably be expected to be finally adjudicated against the health care provider to the extent of the contract obligation.

(b) The association may

(1) employ or retain persons, individual or corporate, to discharge its obligations and pay reasonable compensation for those services;

(2) ~~(5)~~ borrow or advance funds necessary to effectuate the purposes of this association;

(3) ~~(6)~~ negotiate and become a party to those contracts which are necessary to carry out the purposes of the association;

(4) ~~(7)~~ sue or be sued in the name of the association;

(5) ~~(8)~~ cede or assume reinsurance;

(6) ~~(9)~~ perform all other acts necessary and proper to effectuate the association.

Sec. 21.88.160. RATES AND RATING PLANS. The rates and rating plans shall be determined as provided in sec. 80 of this chapter, except that allowance may not be made for income from investment of member-contributed funds; and provided that reserves for claims incurred during the policy period and reasonably expected to be reported after three years after the incident may be included on a different basis due to the additional financial flexibility provided by the association.

Sec. 21.88.170. ASSESSMENT. If sufficient funds are not available for the sound financial operation of the association, all members shall contribute to the financial requirements of the association by paying to the association an assessment to be determined by the board of ~~governors~~ directors of the association, these assessments to be prorated among all members in proportion to their direct written premiums or revenues in this state in the insurance lines the writing of which require membership in the association, in the two years ending on the preceding December 31, after deducting the applicable cancellations, returned premium, the unabsorbed portion of any deposit premium, all policy dividends, unabsorbed premiums refunded to policyholders, refunds, savings, savings coupons and

other similar returns paid or credited to policyholders with respect to their policies. Any assessment under this section is a tax obligation in addition to taxes required under AS 21.09.210 and notwithstanding the provisions of AS 21.09.210(e).

Sec. 21.88.180. RATE ADJUSTMENT. (a) If in any year an assessment is made under sec. 170 of this chapter, rates for the next period shall be increased from the rate determined under sec. 160 of this chapter by an amount sufficient to reimburse all members the amounts assessed.

(b) No assessment may be reimbursed to members without prior approval of the director and no interest accrues in favor of members on amounts assessed.

(c) If, after establishing required reserves, there is an excess amount in reserve, the excess premium shall be refunded to the insured health care providers.

Sec. 21.88.190. REPORTS. At least annually the association shall report to the director concerning its affairs. The report shall be in the form prescribed by the director.

ARTICLE 4. LOAN FUND.

Sec. 21.88.210. FUND ESTABLISHED. (a) There is in the Department of Commerce and Economic Development a medical malpractice liability revolving loan fund to be administered by the director of insurance.

(b) Loans may be made from the fund to the corporation and to the association upon certification by the director that a loan is necessary for the corporation or association to spread costs out over time because of fluctuations in loss experience. If a loan is made to the corporation or the association from the fund, the borrower shall issue a note to the fund pledging the premiums collected in the future as security for the loan.

(c) Loans from the fund shall be repaid within five years at an annual interest rate of six per cent.

(d) The director may sell at par value to the Department of Revenue the notes, security instruments and pledge agreements held by the Department of Commerce and Economic Development as security for loans made under this section. The Department of Revenue shall purchase all the notes offered until the current principal amount of the notes purchased and held by the Department of Revenue equals $5,000,000.

LAL 20

EXAMPLE

AS 08.20 is amended by adding a new section to read:

Sec. 08.20.115. MALPRACTICE INSURANCE. If medical malpractice insurance for chiropractors becomes unavailable on the voluntary market, and the director of insurance finds, after public hearing, that the unavailability is impairing the delivery of chiropractic services to the public, the director of insurance may require all persons licensed under this chapter to carry malpractice insurance and to purchase their insurance from the Health Care Providers Indemnity Corporation established under AS 21.88.

AS 08.20.120 is amended by adding a new paragraph to read:

(8) complies with the provisions of sec. 115 of this chapter.

EXAMPLE

AS 08.20 is amended by adding a new section to read:

Sec. 08.20.115. MALPRACTICE INSURANCE. If medical malpractice insurance for chiropractors becomes unavailable on the voluntary market, and the director of insurance finds, after public hearing, that the unavailability is impairing the delivery of chiropractic services to the public, the director of insurance may require all persons licensed under this chapter to carry malpractice insurance and to purchase their insurance from the Health Care Providers Indemnity Corporation established under AS 21.88.

AS 08.20.120 is amended by adding a new paragraph to read:

(8) complies with the provisions of sec. 115 of this chapter.

(1)

Allow 60 day closing off period

AS 09.55.530 is repealed & re-enacted to read:

ARTICLE 6. MALPRACTICE ACTIONS.

Sec. 09.55.530. DECLARATION OF PURPOSE. The legislature finds that the health of the people is threatened by curtailment of health care services due to the difficulty in obtaining adequate malpractice insurance at a reasonable cost. It is the purpose of secs. 530 - 560 of this chapter to protect the health and safety of the people of this state by establishing procedural aids for handling malpractice claims which will help ensure the ready availability of adequate insurance at a reasonable cost and which will be fair to all parties concerned.

Sec. 09.55.535. VOLUNTARY ARBITRATION. (a) A patient and any health care provider may execute an agreement to submit to arbitration any dispute, controversy, or issue arising out of care of treatment by the health care provider during the period that the agreement is in force or that has already arisen between the parties.

(b) An agreement to arbitrate executed before care or treatment is provided between a patient and health care provider shall clearly provide in bold print on the face of the agreement that execution of the agreement by the patient is not a prerequisite to receiving care or treatment. If this subsection is not complied with by the health care provider, the agreement to arbitrate is void. The form to be used shall be approved in advance by the (Attorney General director of insurance) to assure it fairly informs the patient and properly protects his interests.

(c) Each admission to a hospital shall be treated as separate and distinct for the purposes of an agreement to arbitrate, but a person receiving outpatient care from a hospital or clinic or a member of a health maintenance organization may execute an agreement with the hospital which provides for continuation of the agreement for a continuing program of treatment or during continued membership.

(d) The arbitration board shall consist of three arbitrators: one arbitrator designated by the plaintiff or plaintiffs, one arbitrator designated by the defendant or defendants, and a third arbitrator designated by mutual agreement who shall serve as chairman of the board. If the parties cannot agree on the third person, the court will provide a list of three or more persons who might serve as chairman of the arbitration board, which shall be furnished by the attorney general. Plaintiff or plaintiffs together and defendant and defendants together may each strike one or more names from the list, so after each side has done so, at least one name remains on the list, providing a basis for the final selection by the court.

(e) The attorney general shall prepare a list of panelists consisting of lawyers or other persons qualified to serve as chairmen of arbitration boards. They shall be selected on basis of their technical expertise, judicial temperament, and capability of impartially acting on malpractice claims. The attorney general shall submit a list of at least three names of panelists whenever requested to do so by the court along with detailed biographical information on each panelist.

(f) Each member of the board shall receive reasonable compensation to be paid by the court based on the extent and duration of services rendered. The court shall also pay the costs of experts required by the board, to a maximum of $150/day for each of 3 experts for each party.

(g) The court shall specify the shortest practical deadline for completion of the work of the arbitration panel, taking into account all the circumstance and the nature of the case.

(h) The provisions of the Uniform Arbitration Act, AS 09.43.010 - 09.43.180, apply to arbitrations under this section insofar as they are applicable and do not conflict with the provisions of this section; arbitrations under this section shall be conducted in accordance with any rules of court which may be adopted.

(i) It shall be a condition of the arbitration agreement that the results are binding on both parties

* Sec. 15. AS 09.55 is amended by adding a new section to read:

Sec. 09.55.535. EXPERT ADVISORY PANEL. (a) In any action for damages due to personal injury or death based upon the provision of professional services by a health care provider, the court shall establish a three-person expert advisory panel in accordance with this section. When the action is filed the court shall, by order, determine the professions or specialties to be represented on the expert advisory panel and shall advise each party of the professions or specialties to be represented, giving the parties the opportunity to object or make suggestions. The court may in its discretion conduct other preliminary proceedings relative to the composition of the panel as it considers appropriate.

(3)

(b) The expert advisory panel may compel the attendance of witnesses, interview the parties and physically examine the injured person if alive, consult with the specialists or learned works they consider appropriate, and compel the production of and examine all relevant hospital, medical, or other records or materials relating to the health care treatment. The panel may meet in camera, but shall maintain a record of any testimony or oral statements of witnesses, and shall keep copies of all written statements and opinions it receives. Not more than 30 days after selection of the panel, it shall make a written report to the parties and to the court, substantially answering the following questions in addition to any other question which the court puts to the panel:

(1) What was the medical complaint or condition for which the person sought or was brought to medical care?

(2) What would have been the likely course of the complaint or condition without the medical care?

(3) Was the care appropriate?

(4) Did an injury arise from the medical care?

(5) What was the injury?

(6) Is the injury stable; or will it improve or become worse?

(7) What specifically caused the injury?

(8) Was the injury caused by negligence?

(9) Is the outcome different than would otherwise have been expected?

(c) In any case in which the answer to one or more of the questions under (b) of this section depends upon the resolution of factual questions which are not the proper subject of expert opinion, the report shall so state and may answer questions based upon hypothetical facts that are fully and completely set out in the opinion. The report shall include copies of all written statements, opinions, or records relied upon by the panel and either a transcription or other record of any oral statements or opinions; shall specify any medical or scientific authority relied upon by the panel; and shall include the results of any physical or mental examination performed on the plaintiff. Each member shall sign the report and his signature constitutes his adoption of all statements and opinions contained in it; however, a member may, instead of signing the report, submit a concurring or dissenting report which complies with the requirements of this subsection, and a member may not attest to any portion of the report as to which he is not qualified to give expert testimony.

(d) No discovery may be undertaken in a case until the report of the expert advisory panel is received. However, the court may relax this prohibition upon a showing of good cause by any party. If the panel has not completed its report within the 30-day period prescribed in (b) of this section, the court may, upon application, grant it an additional 30 days.

(e) The report of the panel and any dissenting or concurring opinion are admissible in evidence to the same extent as though its contents were orally testified to by the person or persons preparing it. The court shall delete any portion that would not be admissible because of lack of foundation for opinion testimony, or otherwise. Either party may submit expert testimony to support or refute the report. The jury shall be instructed in general terms that the report shall be considered and evaluated in the same manner as any other expert testimony. Any member of the panel may be called by any party and may be cross-examined as to the contents of the report or of his dissenting or concurring opinion.

(f) Members of a panel are entitled to travel expenses and per diem in accordance with state law pertaining to members of boards and commissions for all time spent in preparing its report and matters incidental to it. If a panel member is called upon as a witness at trial or upon deposition, he is entitled to payment of an expert witness fee. All expenses incurred by the panel shall be paid by the ~~state~~ court. However, in any case in which the court determines that a party has made a patently frivolous claim or a patently frivolous denial of liabilit , it shall order that all costs of the expert advisory panel be borne by the party making that claim or denial.

(g) Parties to the case and their counsel may not initiate communication out of court with members of the panel on the subject matter of its inquiry and report or cause or solicit others to do so, except through ordinary discovery proceedings.

A M E N D M . T

TO: Senate CS for CS for House Bill No. 57[illegible] am S

Page 4, after line 29: Insert the following:

Sec. 08.64.221. PERIODIC REEXAMINATION. In order to maintain a license under this chapter, a licensee shall be reexamined every five years by the board to test the licensee's fitness to continue practicing medicine or osteopathy in the state.

A M E N D M E N T

TO: Senate CS for CS for House Bill No. 574 am S

Page 4, after line 29: Insert the following:

Sec. 08.64.221. PERIODIC REEXAMINATION. In order to maintain a license under this chapter, a licensee shall be reexamined every five years by the board to test the licensee's fitness to continue practicing medicine or osteopathy in the state.

March 15, 1976

SUGGESTED CHANGES IN SCS CSHB 574AM
in addition to changes already suggested for CS HB574

p.1	l.	23-24	Would a retired practitioner be eligible to be a lay person on a board?
p.1	l.	27	New board member terms should all start at same time, like July 1.
p.4	l.	1-5	Delete "residing in as many separate judicial districts as possible".
	l.	3-5	Retain election by ASMA.
p.10	l.	20-21	Change "A physician or hospital" to "a health care provider".
p.11	l.	7	Change "panelists" to "arbitrators".
	l.	12	Change "panelists" to "arbitrators".
	l.	13	Change "panelists" to "person".
	l.	~~19~~ 22	Change "panel" to "board".
p.12	l.	8 5	After "opinions" add "and the opinion of the expert advisory panel".
l.	17	~~14~~	Add subsection (j) to read: "If an expert advisory panel was not used by the arbitration board, such a panel, with the powers of the expert advisory panel under Sec. 537 of this chapter, shall be appointed by the court prior to a trial de novo unless the court decides that an expert advisory panel is not necessary for a decision in the case."
p.12	l.	~~27~~ 29	Change "director of insurance" to "attorney general".
p 13	l.	28 1	Change "the patient" to "both parties". Change "his" to "their".
p.13	l.	~~13~~ 16	Expert advisory panel language of house bill p.10 line 10 to page 13 line 2 with suggested additions should be inserted into senate bill as senate bill does not des be the constitution or duties adequately.
p.25	l.	~~15~~ 20	Strike ", attorneys,".
p.~~27~~ 26	l.	28 4	Add after "1974" "for any period".
p.39	l.	~~24-25~~ 29	Wording incorrect since floor amendments about expert advisory panels.
p40	l.	1	

March 15, 1976

SUGGESTED CHANGES TO CSHB 574

p.2 l. 2-6 and similar sections for other boards

Change to read:
"That by reason of demonstrated deficiency of competence, experience, or education, or because of physical or mental illness, the authority to practice should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice, require further formal education approved by the board, or may suspend or revoke the license."

p.10 l. 19

After "suggestions." insert a new sentence to read:
"Ordinarily the panel will consist of physicians, but any person expert in the matter of the claim may be appointed to the panel."

p.11 l. 15-13

Strike present wording and substitute:
"(1) What was the disorder for which the person sought medical care?
(2) What would have been the outcome without medical care?
(3) Was the treatment selected appropriate for the case?
(4) Did an injury arise from the medical care?
(5) What is the injury?
(6) How extensive and how disabling is the injury?
(7) Is the injury stable; or will it improve or become worse?
(8) What specifically caused the injury?
(9) Was the injury the result of negligent medical care?
(10) Is the outcome different than would otherwise have been expected?"

p.11 l. 17-18

After "state" delete remainder of sentence.

p.14 l. 1
l. 2

Change "increase" to "adjusted"
Change "increase" to "changes"

p.16 l. 23

Add waiver for insured hospitals until 1-1-77.

p.19 l. 15

Add new section to read:
"18.23.035 guidlines not admissible in evidence. A guideline established by a review organization is not admissible in evidence in a proceeding brought by or against a health care provider by a person to whom the provider has rendered professional services."

p.23 l. 25

Delete "of $100 per day."

p.30 l. 29

After "arising" add "from acts, errors, or omissions".

Alaska State Medical Association

574

SUGGESTED RE-WORDING FOR 08.20.175 etc. p.1-10

In addition to action under Sec. 170 of this chapter, upon a finding that by reason of deficiency of competence, experience, or education, ~~and/~~or by reason of physician ~~or~~ or mental illness, the authority to practice should be limited or conditioned or the practitioner disciplined, the Board may reprimand, censure, place on probation, restrict practice, require futher formal education approved by the Board, or may suspend or revoke the license.

Alaska State Medical Association

SUGGESTED RE-WORDING OF QUESTIONS FOR EXPERT ADVISORY PANEL p.11 HB

(1) What was the medical complaint or condition for which the person sought or was brought to medical care?

(2) What would have been the likely course of the complaint or condition without the medical care?

(3) Was the care appropriate?

(4) Did an injury arise from the medical care?

(5) What was the injury?

(6) Is the injury stable; or will it improve or become worse?

(7) What specifically caused the injury?

(8) Was the injury caused by negligence?

Colletta & Rodey

Suggested Amendment for Senate Bill SCSCSHB 574 am S

Page 19 Section 18.20.045 - to replace Subsection (b)

Suggested Amendment for Section 18.20.045 - House Bill CSHB 574 am page 16

Addition to House Bill:Amendment would be added as subsection (a)

The Director of Insurance or his designee shall waive the requirement in (a) of this section for a hospital if the hospital furnishes satisfactory evidence of having other liability insurance providing coverage in amounts equal to or which exceed those specified in (a) of this section, and at a premium rate which does not exceed the premium rate offered by the Health Care Providers Indemnity Corporation for an equal amount of liability coverage. A waiver granted under this subsection may extend beyond the normal expiration date of the hospital's insurance policy or until such time as the policy's premium rate exceeds that which would be offered by the Health Care Providers Indemnity Corporation for an equal amount of coverage.

This should be added to 25.18.20.01.

(c) The Director of Insurance may waive the requirement in (a) of this section or permit a deductible provision in the policy for a hospital, if the hospital:

i) can demonstrate to the satisfaction of the Director of Insurance that without indemnity from any other source, the hospital has the financial resources to discharge the maximum potential exposure to the hospital by reason of the deductible provision.

ii) agree to permit the Health Care Providers Indemnity Corporation to provide defense of any claim brought against the hospital if any health care provider insured by the corporation is also involved in the claim and to reimburse the corporation for a prorata portion of the costs of defense.

iii) provides the Health Care Providers Indemnity Corporation with notice of any claim brought against it.

Mr. Richard Block

ALASKA
STATE LEGISLATURE

March 12, 1976

MEMORANDUM

Jerry,

Enclosed are a few radical amendments. I don't know if you'll approve of the ~~fee~~ amendment re donation of time of physicians. The approach was the way they began in California - but it's been watered down quite a bit since then. Let me know what changes you want. Have

A M E N D M E N T

TO: SENATE CS FOR CS FOR HOUSE BILL NO. 574 am S

Page 5, between lines 10 and 11: insert the following new section and renumber the remaining sections accordingly:

* Sec. 14. AS 08.04.311 is amended to read:

Sec. 08.64.311. BIENNIAL LICENSE RENEWAL. Licenses shall be renewed biennially upon a showing of proof by the licensee that he or she has dedicated 10 days each year of his or her time without compensation to the treatment and care of persons eligible for medical assistance under AS 47.07.

A M E N D M E N T

TO: SENATE CS FOR CS FOR HOUSE BILL NO. 574 am S

Page 5, between lines 10 and 11: insert the following new section and renumber the remaining sections accordingly:

* Sec. 14. AS 08.04.311 is amended to read:

Sec. 08.64.311. BIENNIAL LICENSE RENEWAL. Licenses shall be renewed biennially upon a showing of proof by the licensee that he or she has dedicated 10 days each year of his or her time without compensation to the treatment and care of persons eligible for medical assistance under AS 47.07.

A M E N D M E N T

TO: Senate CS for CS for House Bill No. 574 am S

Page 3, lines 27 through page 4, line 5: Delete all material and insert:

* Sec. 10. AS 08.64.010 is amended to read:

Sec. 08.64.010. CREATION AND MEMBERSHIP OF STATE MEDICAL BOARD. The governor shall appoint a board of medical examiners, to be known as the State Medical Board, consisting of <u>seven persons with no direct financial interest in the health care industry</u> [FIVE LICENSED PHYSICIANS], residing in as many separate Alaska judicial districts as possible. [EACH MEMBER SHALL BE CHOSEN FROM A PANEL OF THREE, FOR EACH VACANCY, SUBMITTED TO THE GOVERNOR BY THE ALASKA STATE MEDICAL ASSOCIATION.]

Page 4, lines 6 through 12: Delete all material and renumber the remaining sections accordingly.

A M E N D M E N T

TO: Senate CS for CS for House Bill No. 574 am S

Page 3, lines 27 through page 4, line 5: Delete all material and insert:

* Sec. 10. AS 08.64.010 is amended to read:

Sec. 08.64.010. CREATION AND MEMBERSHIP OF STATE MEDICAL BOARD. The governor shall appoint a board of medical examiners, to be known as the State Medical Board, consisting of <u>seven persons with no direct financial interest in the health care industry</u> [FIVE LICENSED PHYSICIANS], residing in as many separate Alaska judicial districts as possible. [EACH MEMBER SHALL BE CHOSEN FROM A PANEL OF THREE, FOR EACH VACANCY, SUBMITTED TO THE GOVERNOR BY THE ALASKA STATE MEDICAL ASSOCIATION.]

Page 4, lines 6 through 12: Delete all material and renumber the remaining sections accordingly.

Page 15, line 3 ...care may revoke the agreement within ~~seven~~ 30 calendar days after execution....

line 5 ...after its execution. The period for revocation shall be tolled during any period that the person receiving health care is physically disabled from executing such a revocation. An arbitration agreement entered into by the parents or legal guardian of a minor person receiving health care shall be binding upon such minor person.

Page 16, line 27 ...unless [the court decides] all parties shall agree that an expert advisory opinion is not...

Possible Standard for court

Page 18, line 16 ...opinion, except that the non-appearance of a member of the panel for cross-examination shall not for that reason render the report inadmissable.

line 20 ...However, the court may [relax this prohibition upon a showing of good cause by any party] permit, prior-



to receipt of the report, such discovery as the court may, after good cause showing, find must be undertaken to preserve evidence which would otherwise be unobtainable.

O.K. Page 21, line 5 ...The court [shall] may take into account...

O.K. change subject to A.B.A. Page 24, line 24 ....by regulation [and submit to the legislative Administrative Regulation Review Committee standards for] risk management programs...

No. Page 30, line 17 ...two [professionals from] executives of insurance...

* [Page 33, line 14 insert in place of (3) the following language:

(3) negotiate for and procure reinsurance from a casualty insurer or reinsurer for all of its liability

incurred by contracts issued under (1) of this subsection; the corporation may not incur or retain under those contracts liability with respect to claims reported within 3 years after date of occurrence which is not reinsured as provided in this paragraph; if, after the exercise of due diligence, no reinsurance for all or a portion of the risk can be procured at reasonable rates from casualty insurers or reinsurers, the corporation through the board of governors, shall so certify to the Director of Insurance and reinsurance shall then be provided by the Health Care Joint Underwriting Association as provided in Sec. 110 et. seq of this chapter for that portion not reinsured by a private carrier.

The original (3) shall then be numbered as (4)

The original (4) shall then be numbered as (5)

The original (5) shall then be numbered as (6)

The original (6) shall then be numbered as (7)

Page 34, line 17 (2) all language shall be deleted and its place the following language shall be inserted:

(2) cede reinsurance for all or any portion of the risk underwritten by the Corporation or reinsure any risk which the Corporation is authorized or required to insure by the issuance of a policy.

Page 37, line 19 insert the following:

(14) Provision for expectation of underwriting profit to any reinsurer except the Association shall be included

in the rate at reasonable levels except that no increase-ment for expectancy of underwriting profit shall be included in the rate making for a private insurer of the primary layer of reinsurance with respect to claims reported within three years after date of occurrence during any period that the claims reported after three years after date of occurrence are not reinsured with minimum reinsurance with a private insurer or re-insurer. If, while there shall be less than minimum reinsurance in force, premiums for claims reported within three years after date of occurrence exceed claims and reserves with respect to claims reported within three years after date of occurance and operating expenses, such excess shall be added to the portion of premiums collected to discharge claims and reserves reported after three years after date of occurrence.

Minimum reinsurance for the purpose of this section means reinsurance of all risk with respect to claims reported after three years after date of occurrence. with the exception that MICA may, if not otherwise reinsurable retain up to the first $50,000 of each and every loss and an aggregate loss of not more than $500,000 per year.

Page 38, line 24 ...appointed by the [governor of the state] Director

NO. and consisting of two.....

Page 40, line 8 delete (1) and replace it with the following language:

(1) provide reinsurance to the corporation covering contracts issued by the ~~by the~~ corporation indemnifying health care providers and their employees who are health care providers against loss by reason of liability for professional services and agreeing to tender on behalf of the health care providers and their employees who are health care providers a defense in an action brought under AS 09.55.530 - 09.55.560; the limit of liability shall be no less than the minimum liability required to be indemnified as provided in AS 08.64.215 and AS 18.20.045, and the coverage shall be the same as that which the Health Care Providers Indemnity Corporation is required to provide under sec. 50 of this chapter ~~with respect only to claims reported within three years after date of occurrence.~~ To the extent reinsurance is not provided by private [illegible] casualty insurers or reinsurers.

Page 41, line 1 ...premium shall be refunded to the [association] corporation

Plan A (i)

OK, Page 42, line 29 ...to the corporation [and to the ...

Page 43, line 1 ...association] upon certification by the director that a loan is necessary for the following purposes. insert the following language:

Subordinated note payout pro rata

i. a loan or loans not to exceed outstanding at any one time an aggregate of $3,000,000 to be used to provide surplus in respect of policyholders. These obligations shall be subordinated to all other obligations of the corporation and be repayable in annual installments of no less than ~~twenty five~~ percent of the excess, if any, to which the premiums from insureds exceed claims, reserves, expenses, ~~repayment of loans provided for in subsection (i) hereof~~ and assessments made by the Association if any. Interest shall be paid on the outstanding balance at a rate equal to the from time to time yield from the investment of such funds less a reasonable charge for investment expense.

Interest rate at existing bank rates

out

ii. A loan or loans not to exceed, when taken together with loans provided for in i) hereof, outstanding at any one time, because of fluctuations in loss experience These obligations shall have parity with all other obligations of the corporation except that they shall be subordinated to obligations to policyholders or claimants for indemnity of loss and shall be repaid within five years at an annual interest rate, ~~of~~ six per cent.

out

aggregate of $6,000,000

~~iii.~~ Loans pursuant to this subsection (i) shall not be authorized for any period that the limit is fully exhausted.

Page 43, line 1-7 Delete (b) and (c) ~~for the amended language~~.

Page 43 line 12 ...all the notes offered until the [current] principal ...

line 13 ...Department of Revenue at any one time equals $6,000,000. [$5,000,000]

Page 45, line 22 add the following language:

O K. Sections ~~34 — 39~~ 33 — 38 of this Act shall be applicable to all actions, including those arising out of incidents occurring prior to the effective date of this act, in which trial has not commenced prior to the effective date hereof. [cases where not filed] immediate effective date for this section

Page 45 Sec. 49 Severability. In the event any portion of this Act shall be held unconstitutional all other portions shall remain in full force and effect except that if any portion of Article 3, Chapter 88 of Title 21. A.S. 21.88.110 through 21.88.190 shall be held unconstitutional then the whole article shall be null and voi except that the Joint Underwriting Association shall continue to discharge and assess to pay for claims incurred prior to declaration of unconstitutionality until all such claims have been paid.and except further that if it is held unconstitutional to require that Health Care Providers procure liability insurance from the Medical Indemnity Corporation of Alaska, then all of

sections 41, 42, 43 and 44 of this act shall be null and void except that the Medical Indemnity Corporation of Alaska and Joint Underwriting Association shall continue to discharge and assess to pay claims incurred prior to declaration of unconstitutionality until all such claims have been paid.

EXAMPLE

Sec. 08.20.115. MALPRACTICE INSURANCE. If medical malpractice insurance for chiropractors becomes unavailable on the voluntary market, and the director of insurance finds, after public hearing, that the unavailability is impairing the delivery of chiropractic services to the public, the director of insurance may require all persons licensed under this chapter and carrying malpractice insurance to purchase their insurance from the Health Care Providers Indemnity Corporation established under AS 21.88.

* Sec. 5. AS 08.20 is amended by adding a new section to read:

Sec. 08.20.175. LIMITS OR CONDITIONS ON LICENSE; REPRIMAND. (a) In addition to action under sec. 170 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education or health the authority to practice chiropractic should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 6. AS 08.32 is amended by adding a new section to read:

Sec. 08.32.165. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 160 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education or health the authority to practice dental hygiene should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 2. AS 08.20 is amended by adding new sections to read:

Sec. 08.20.115. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance against liability to patients for chiropractic malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require all persons licensed under this chapter to obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for chiropractors is impairing the delivery of chiropractic services to the public.

Sec. 08.20.175. LIMITS OR CONDITIONS ON LICENSE; REPRIMAND. (a) In addition to action under sec. 170 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice chiropractic should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 3. AS 08.32 is amended by adding new sections to read:

Sec. 08.32.015. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $100,000 per occurrence and $300,000 aggregate liability per year. This requirement is satisfied if the person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require all persons licensed under this chapter to obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for dental hygienists is impairing the delivery of dental hygienists' services to the public.

Sec. 08.32.165. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 160 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice dental hygiene should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 7. AS 08.36.010 is amended to read:

Sec. 08.36.010. CREATION AND MEMBERSHIP OF BOARD. There is created the Board of Dental Examiners, referred to in this chapter as the board, consisting of seven [FIVE] members. Five members [EACH MEMBER] shall be [A CITIZEN OF THE UNITED STATES AND A] qualified resident dentists who have [HAS] been engaged in the practice of dentistry in the state for five years immediately preceding [HIS] appointment, and two members shall be persons with no direct financial interest in the health care industry.

* Sec. 8. AS 08.36.020 is amended to read:

Sec. 08.36.020. APPOINTMENT AND TERM OF SERVICE OF MEMBERS. Members of the board are appointed by the governor, subject to confirmation by the legislature in joint session [ASSEMBLED]. Each board member serves for a term of five years, and until his successor is appointed and qualified except that the terms of the public members on the board shall be staggered so that they do not expire at the same time. The term begins on February 1. An appointment to a vacancy is for the unexpired term. [APPOINTMENTS SHALL BE MADE FROM A LIST OF NAMES RECOMMENDED BY THE ALASKA DENTAL SOCIETY. THE LIST SHALL BE SUPPLIED AT LEAST 30 DAYS BEFORE THE BEGINNING OF A TERM AND NOT MORE THAN 60 DAYS AFTER THE OCCURRENCE OF A VACANCY. THE LIST SHALL CONTAIN AT LEAST TWO RECOMMENDED NAMES FOR EACH APPOINTMENT. THE GOVERNOR SHALL MAKE THE APPOINTMENT WITHIN 30 DAYS AFTER RECEIVING THE LIST.]

* Sec. 9. AS 08.36 is amended by adding a new section to read:

Sec. 08.36.325. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 320 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health, the authority to practice dentistry should be limited or conditioned or the practitioner disciplined, the board may censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

* Sec. 4. AS 08.36 is amended by adding new sections to read:

Sec. 08.36.115. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance against liability to patients for dental malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require all persons licensed under this chapter to obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for dentists is impairing the delivery of dentist services to the public.

Sec. 08.36.325. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 320 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice dentistry should be limited or conditioned or the practitioner disciplined, the board may censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 10. AS 08.64.010 is amended to read:

Sec. 08.64.010. CREATION AND MEMBERSHIP OF STATE MEDICAL BOARD. The governor shall appoint a board of medical examiners, to be known as the State Medical Board, consisting of five licensed physicians, residing in as many separate Alaska judicial districts as possible, and two persons with no direct financial interest in the health care industry. [EACH MEMBER SHALL BE CHOSEN FROM A PANEL OF THREE, FOR EACH VACANCY, SUBMITTED TO THE GOVERNOR BY THE ALASKA STATE MEDICAL ASSOCIATION.]

* Sec. 11. AS 08.64.020 is amended to read:

Sec. 08.64.020. STATE MEDICAL BOARD TERM OF OFFICE. Members shall be appointed for a term of four years, subject to confirmation by a majority of the members of the legislature in joint session, and shall hold office until their successors are appointed and qualified. The terms of the public members of the board shall be staggered so that they do not expire at the same time.

* Sec. 12. AS 08.64.090 is amended to read:

Sec. 08.64.090. QUORUM. Four [THREE] members of the board constitute a quorum for the transaction of all business properly before the board.

* Sec. 13. AS 08.64 is amended by adding new sections to read:

Sec. 08.64.215. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person shall maintain insurance issued by the Health Care Providers Indemnity Corporation against liability to patients for medical malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year.

(b) The director of insurance or his designee shall waive the requirement in (a) of this section for a person if that person furnishes satisfactory evidence of his having other insurance providing coverage in amounts not less than those specified in (a) of this section. No waiver granted under this subsection may extend beyond the normal expiration date of the person's insurance policy or January 1, 1977, whichever occurs first.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 5. AS 08.64 is amended by adding new sections to read:

Sec. 08.64.215. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance issued by the Health Care Providers Indemnity Corporation against liability to patients for medical malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him from the Health Care Providers Indemnity Corporation in the required amounts.

(b) The director of insurance or his designee may waive the requirement in (a) of this section for a person if that person furnishes satisfactory evidence of his having other insurance providing coverage in amounts not less than those specified in (a) of this section. No waiver granted under this subsection may extend beyond the normal expiration date of the person's insurance policy or January 1, 1977, whichever occurs first.

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Sec. 08.64.325. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 330 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 14. AS 08.68.010 is amended to read:

Sec. 08.68.010. CREATION AND MEMBERSHIP OF BOARD OF NURSING. There is created a Board of Nursing, consisting of seven [FIVE] members appointed by the governor. One member shall be currently involved in institutional nursing service, one member in community or public health nursing and two members in basic or continuing nursing education, [AND] one nurse at large, and two persons who have no direct financial interest in the health care industry.

* Sec. 15. AS 08.68.020 is repealed and re-enacted to read:

Sec. 08.68.020. TERM OF OFFICE. Members serve staggered terms of five years and until their successors are appointed. The terms of the public members on the board shall be set so that they do not expire at the same time. Vacancies on the board shall be filled for the unexpired term.

* Sec. 16. AS 08.68.060 is amended to read:

Sec. 08.68.060. QUALIFICATIONS OF BOARD MEMBERS. The five members [EACH MEMBER] of the board who are nurses shall be [A CITIZEN OF THE UNITED STATES, A RESIDENT OF THE STATE, AND A] licensed professional nurses [NURSE] in the state, and [MEMBERS] shall have been actively

shall promote a high degree of competence in the practice of medicine by requiring every physician licensed in the state to fulfill continuing education requirements.

(b) Before a license may be renewed the licensee shall submit evidence to the board that continuing education requirements prescribed by regulations adopted by the board have been met.

(c) The board may exempt a physician from the requirements of (b) of this section upon an application by him giving evidence satisfactory to the board that he is unable to comply with the requirements because of extenuating circumstances. However, no person may be exempted from more than 15 hours of continuing education in a five-year period.

Sec. 08.64.325. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 330 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

two years of which were within the five years preceding appointment.

* Sec. 6. AS 08.68 is amended by adding new sections to read:

Sec. 08.68.165. INSURANCE REQUIRED. (a) To be eligible for an active license as a nurse under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $100,000 per occurrence and $300,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require all persons licensed under this chapter to obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for nurses is impairing the delivery of nurse services to the public.

Sec. 08.68.275. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 270 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice nursing should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 17. AS 08.68 is amended by adding a new section to read:

Sec. 08.68.275. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 270 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice nursing should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 18. AS 08.71.020 is amended to read:

Sec. 08.71.020. MEMBERSHIP OF BOARD; SOURCE OF APPOINTMENTS; TERM OF OFFICE. The board consists of <u>seven</u> [FIVE] persons appointed by the governor. <u>Members serve staggered terms of three years. The terms of the public members of the board shall be set so that they do not expire at the same time.</u> [THE GOVERNOR SHALL APPOINT BOARD MEMBERS FROM A LIST OF QUALIFIED OPTICIANS PREPARED BY THE ASSOCIATION OF OPTICIANS IN THE STATE AND SUBMITTED AT LEAST 30 DAYS BEFORE JULY 1, 1973, AT LEAST 30 DAYS BEFORE THE EXPIRATION OF A TERM AND NOT MORE THAN 60 DAYS AFTER A VACANCY OCCURS IN AN UNEXPIRED TERM. THE LIST SHALL CONTAIN NOT LESS THAN TWO RECOMMENDED CANDIDATES FOR EACH APPOINTMENT. THE GOVERNOR SHALL MAKE APPOINTMENTS WITHIN 30 DAYS AFTER RECEIVING THE LIST. THE TERM OF OFFICE OF EACH MEMBER IS THREE YEARS. HOWEVER, OF THE FIRST MEMBERS OF THE BOARD, ONE SHALL BE APPOINTED FOR A ONE-YEAR TERM, TWO FOR TWO-YEAR TERMS, AND TWO FOR THREE-YEAR TERMS.] Vacancies on the board shall be filled for the unexpired term [IN THE SAME MANNER AS ORIGINAL APPOINTMENT].

* Sec. 19. AS 08.71.030 is amended to read:

Sec. 08.71.030. QUALIFICATIONS OF BOARD MEMBERS. Five [A] board members [MEMBER] shall be [A] licensed, practicing dispensing opticians [OPTICIAN] residing in the state. Two shall be persons with no direct financial interest in the health care industry.

* Sec. 20. AS 08.71 is amended by adding a new section to read:

Sec. 08.71.175. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 170 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice as a dispensing optician under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 21. AS 08.72.020 is amended to read:

Sec. 08.72.020. MEMBERSHIP OF BOARD AND TERMS OF OFFICE. The board consists of five [THREE] persons, appointed by the governor. Members serve staggered terms of three years. The terms of the public members of the board shall be set so that they do not expire at the same time. [THE TERM OF EACH MEMBER IS THREE YEARS. ONE MEMBER ONLY IS APPOINTED EACH YEAR, EXCEPT WHEN VACANCIES FOR UNEXPIRED TERMS ARE FILLED.]

* Sec. 22. AS 08.72.040 is repealed and re-enacted to read:

Sec. 08.72.040. QUALIFICATIONS. Three board members shall be licensed, practicing optometrists who have been residents for at least three years. Two shall be persons who have no direct financial interest in the health care industry.

Sec. 7. AS 08.71 is amended by adding new sections to read:

Sec. 08.71.085. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $100,000 per occurrence and $300,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require that all persons licensed under this chapter obtain the insurance required under (a) of this section if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for dispensing opticians is impairing delivery of the services of dispensing opticians to the public.

Sec. 08.71.175. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 170 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice as a dispensing optician under this chapter should be limited or conditioned or the practitioner disciplined the board may reprimand, censure, place on probation, restrict practice by procedure or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 8. AS 08.72 is amended by adding new sections to read:

* Sec. 23. AS 08.72 is amended by adding a new section to read:

Sec. 08.72.255. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under secs. 240 and 250 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice optometry under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 24. AS 08.80.010 is amended to read:

Sec. 08.80.010. CREATION AND MEMBERSHIP OF BOARD OF PHARMACY. There is created the Board of Pharmacy, composed of <u>seven</u> [FIVE] members, <u>five</u> [EACH] of whom shall be <u>pharmacists</u> [A PHARMACIST] licensed in the state who has been actively engaged in the practice of pharmacy in the state for a period of three years immediately preceding his appointment. <u>Two shall be persons with no direct financial interest in the health care industry.</u> Whenever possible, the board shall include at least one member from each judicial district.

* Sec. 25. AS 08.80.020 is amended to read:

Sec. 08.80.020. TERM OF OFFICE. Members of the board are appointed by the governor, and confirmed by the legislature in joint session, for overlapping terms of five years, or until their successors are appointed and qualified. <u>The terms of the public members shall be staggered so that they do not expire at the same time.</u> An appointment to fill a vacancy is for the unexpired term. The term of office begins on April 1 of each year.

* Sec. 26. AS 80.80 is amended by adding a new section to read:

CS.72.115

active license under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $100,000 per occurrence and $300,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require all persons licensed under this chapter to obtain insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for optometrists is impairing delivery of optometrist services to the public.

Sec. 08.72.255. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under secs. 240 and 250 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice optometry under this chapter should be limited or conditionsd or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

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Sec. 08.80.265. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 260 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice pharmacy under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 27. AS 08.84 is amended by adding a new section to read:

Sec. 08.84.185. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 180 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education or health the authority to practice physical therapy should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

Sec. 08.80.115. INSURANCE REQUIRED. (a) To be eligible for active registration as a pharmacist, a person must maintain insurance against liability to patients for malpractice in limits of not less than $100,000 per occurrence and $300,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require that all persons licensed under this chapter obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for pharmacists is impairing delivery of pharmacist services to the public.

Sec. 08.80.265. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 260 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice pharmacy under this chapter should be limited or conditioned or the practitioner disciplined, the board may

reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 10. AS 08.84 is amended by adding new sections to read:

Sec. 08.84.035. INSURANCE REQUIRED. (a) To be eligible for active registration as a physical therapist under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $100,000 per occurrence and $300,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require that all persons licensed under this chapter obtain the insurance required in (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for physical therapists is impairing delivery of physical therapist services to the public.

Sec. 08.84.185. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 180 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice physical therapy should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

Sec. 08.86.010. CREATION AND MEMBERSHIP OF BOARD. There is created a Board of Psychologist and Psychological Associate Examinern. It consists of three licensed psychologists, and two persons who have no direct financial interest in the health care industry.

* Sec. 29. AS 08.86.020 is amended to read:

Sec. 08.86.020. APPOINTMENT AND TERM OF OFFICE. Members of the board are appointed by the governor and confirmed by the legislature for staggered terms of three years. The terms of the public members shall be set so that they do not expire at the same time. A member serves at the pleasure of the governor.

* Sec. 30. AS 08.86 is amended by adding a new section to read:

Sec. 08.86.220. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) Upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice psychology or as a psychological associate under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by time, specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 11. AS 08.86.120 is amended to read:

Sec. 08.86.120. ENTITLEMENT TO LICENSURE. A person who passes the examination given by the board and possesses the insurance required by sec. 125 of this chapter is entitled to be licensed as a psychologist.

* Sec. 12. AS 08.86.160 is amended to read:

Sec. 08.86.160. ASSOCIATES: ENTITLEMENT TO LICENSURE. A person who passes the examination given by the board and who possesses insurance in accordance with sec. 125 of this chapter is entitled to be licensed as a psychological associate.

* Sec. 13. AS 08.86 is amended by adding new sections to read:

Sec. 08.86.125. INSURANCE REQUIRED. (a) To be eligible for active licensure as a psychologist under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $100,000 per occurrence and $300,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The director of insurance may require all persons licensed under this chapter to obtain insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for psychologists is impairing the delivery of psychologist services to the public.

Sec. 08.86.220. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) Upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice psychology or as a psychological associate under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure place on probation, restrict practice by time, specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

ARTICLE 6. MALPRACTICE ACTIONS.

Sec. 09.55.530. DECLARATION OF PURPOSE. The legislature finds that the health of the people is threatened by curtailment of health care services due to the difficulty in obtaining adequate malpractice insurance at a reasonable cost. It is the purpose of secs. 530 - 560 of this chapter to protect the health and safety of the people of this state by establishing procedural aids for handling malpractice claims which will help ensure the ready availability of adequate insurance at a reasonable cost and which will be fair to all parties concerned.

* Sec. 14. AS 09.55.530 is repealed and re-enacted to read:

* Sec. 15. AS 09.55 is amended by adding a new section to read:

* Sec. 31. AS 09.55 is amended by adding new sections to read:

Sec. 09.55.535. MANDATORY ARBITRATION. (a) It is the purpose of these arbitration provisions to establish a system that will provide incentives to settle malpractice disputes without prolonged litigation and that will provide a method by which parties to a medical malpractice claim can obtain a prompt determination of its merits, and the amount of damages, if any, that should be allowed.

(b) Upon the filing of any malpractice claim against a physician or hospital, the claim shall be submitted to an arbitration board; however, submission to an arbitration board may not be required if all parties object to arbitration or if the parties have agreed to follow the procedures prescribed in sec. 536 or sec. 537 of this chapter.

(c) The arbitration board shall consist of three arbitrators: one arbitrator designated by the plaintiff or plaintiffs, one arbitrator designated by the defendant or defendants, and a third arbitrator designated by mutual agreement who shall serve as chairman of the board. If the parties cannot agree on the third person, the court will

provide a list of three or more persons who might serve as chairman of the arbitration board, which shall be furnished by the attorney general. Plaintiff or plaintiffs together and defendant and defendants together may each strike one or more names from the list, so after each side has done so, at least one name remains on the list, providing a basis for the final selection by the court.

(d) The attorney general shall prepare a list of panelists consisting of lawyers or other persons qualified to serve as chairmen of arbitration boards. They shall be selected on basis of their technical expertise, judicial temperament, and capability of impartially acting on malpractice claims. The attorney general shall submit a list of at least three names of panelists whenever requested to do so by the court along with detailed biographical information on each panelist.

(e) Each member of the board shall receive reasonable compensation to be paid by the court based on the extent and duration of services rendered. The court shall also pay the costs of experts required by the board.

(f) The board may appoint an expert advisory panel, with the powers of the expert advisory panel under sec. 537 of this chapter, to advise the board on the medical facts of the case.

(g) The court shall specify the shortest practical deadline for completion of the work of the arbitration panel, taking into account all the circumstance and the nature of the case.

(h) The provisions of the Uniform Arbitration Act, AS 09.43.010 - 09.43.180, apply to arbitrations under this section insofar as they are applicable and do not conflict with the provisions of this section; arbitrations under this section shall be conducted in accordance with any rules of court which may be adopted.

(i) If the decision of the arbitration board is not accepted by

all parties and the parties have not agreed to binding arbitration, any party may appeal the decision of the board to the superior court for a trial de novo. The decision of the arbitration board, including its conclusions as to the merits of the claim and appropriate damages, together with any dissenting opinions, shall be admissible in evidence at trial upon the offer of any party, if the court conducts a review of the arbitration decision and any other relevant information submitted by the parties and concludes that:

(1) the findings of fact by the arbitration board were not clearly erroneous;

(2) the decision is in accordance with applicable law;

(3) the procedures required for conducting the hearing and rendering the decision were followed fairly and properly without prejudice to any party;

(4) any party who has not offered the arbitration decision in evidence may subpoena any member of the arbitration board for purposes of cross-examination.

Sec. 09.55.535. VOLUNTARY ARBITRATION. (a) A patient and any health care provider may execute an agreement to submit to arbitration any dispute, controversy, or issue arising out of care of treatment by the health care provider during the period that the agreement is in force or that has already arisen between the parties.

(b) An agreement to arbitrate executed before care or treatment is provided between a patient and health care provider shall clearly provide in bold print on the face of the agreement that execution of the agreement by the patient is not a prerequisite to receiving care or treatment. If this subsection is not complied with by the health care provider, the agreement to arbitrate is void. The form to be used shall be approved in advance by the director of insurance to assure it fairly informs the patient and properly protects his interests.

(c) Each admission to a hospital shall be treated as separate and distinct for the purposes of an agreement to arbitrate, but a person receiving outpatient care from a hospital or clinic or a member of a health maintenance organization may execute an agreement with the hospital which provides for continuation of the agreement for a continuing program of treatment or during continued membership.

(d) Arbitration shall take place under the same procedures prescribed for mandatory arbitration under sec. 536 of this chapter unless the parties agree otherwise in accordance with general guidelines promulgated as regulations by the director of insurance to assure fairness to the parties.

(e) Reasonable compensation based on the extent and duration of services rendered shall be paid to members of the arbitration board by the court as well as the costs of experts required by the board.

Sec. 09.55.537. ALTERNATIVE TO ARBITRATION. (a) If arbitration under sec. 535 of this chapter is waived by all the parties, and as an alternative to arbitration, the court shall appoint an expert advisory panel to advise the fact finder on the medical facts of the case unless the court decides that an expert advisory opinion is not necessary for a decision in the case. The court shall, by order, determine professions or specialties to be represented on the expert advisory panel and shall advise each party of the professions or specialties to be represented, giving the parties the opportunity to object or make suggestions.

Sec. 09.55.536. EXPERT ADVISORY PANEL. (a) In any action for damages due to personal injury or death based upon the provision of professional services by a health care provider, the court shall establish a three-person expert advisory panel in accordance with this section. When the action is filed the court shall, by order, determine the professions or specialties to be represented on the expert advisory panel and shall advise each party of the professions or specialties to be represented, giving the parties the opportunity to object or make suggestions. The court may in its discretion conduct other preliminary proceedings relative to the composition of the panel as it considers appropriate.

(b) The expert advisory panel may compel the attendance of witnesses, physically or orally examine the parties, consult with specialists or learned works they consider appropriate, and compel the production of, and examine all relevant hospital, medical, or other records relating to health care treatment. The panel may meet in camera, but shall maintain a record of any testimony or oral statements of witnesses, and shall maintain copies of any written statements or opinions that it receives.

(c) Not less than 30 days after selection of the panel, it shall make a written report to the parties and the court answering any questions put to it by the court on medical questions. The report shall include copies of all written statements, opinions, or records relied on by the panel, and either a transcription or other record of any oral statements or opinions; the report shall specify any medical or scientific authority relied upon and shall include the results of any physical or mental examination performed on the plaintiff. Each member shall sign the report and his signature constitutes his adontion of all statements and opinions contained in it; however, a member may, instead of signing the report, submit a concurring or dissenting report which complies with the requirements of this subsection. A member may not attest to any portion of the report as to which he is not qualified to give expert testimony.

(b) The expert advisory panel may compel the attendance of witnesses, interview the parties and physically examine the injured person if alive, consult with the specialists or learned works they consider appropriate, and compel the production of and examine all relevant hospital, medical, or other records or materials relating to the health care treatment. The panel may meet in camera, but shall maintain a record of any testimony or oral statements of witnesses, and shall keep copies of all written statements and opinions it receives. Not more than 30 days after selection of the panel, it shall make a written report to the parties and to the court, substantially answering the following questions in addition to any other question which the court puts to the panel:

(1) Was the claimant adversely affected by any act or omission in the rendering of the medical services?

(2) What was the adverse effect?

(3) How did the medical services alter the natural course of the preexisting disorder for which the services were originally rendered?

(4) How did the medical condition existing after performance of the medical services differ from the medical condition which might otherwise have been expected?

(c) In any case in which the answer to one or more of the questions under (b) of this section depends upon the resolution of factual questions which are not the proper subject of expert opinion, the report shall so state and may answer questions based upon hypothetical facts that are fully and completely set out in the opinion. The report shall include copies of all written statements, opinions, or records relied upon by the panel and either a transcription or other record of any oral statements or opinions; shall specify any medical or scientific authority relied upon by the panel; and shall include the results of any physical or mental examination performed on the plaintiff. Each member shall sign the report and his signature constitutes his adoption of all statements and opinions contained in it; however, a member may, instead of signing the report, submit a concurring or dissenting report which complies with the requirements of this subsection, and a member may not attest to any portion of the report as to which he is not qualified to give expert testimony.

(d) The report of the panel and any dissenting or concurring opinion are admissible in evidence to the same extent, and have the same force and effect, as though its contents were orally testified to by the person or persons preparing it. The court shall delete any portion that would not be admissible because of lack of foundation for opinion testimony, or otherwise. Either party may submit expert testimony to support or refute the report. The jury shall be instructed in general terms that the report shall be considered and evaluated in the same manner as any other expert testimony. Any member of the panel may be called by any party and may be cross-examined as to the contents of the report or of his dissenting or concurring opinion.

(e) Members of a panel are entitled to travel expenses and per diem in accordance with state law pertaining to members of boards and commissions for all time spent in preparing its report and matters incidental to it, which shall be paid by the court. If a panel member is called upon as a witness at trial or upon deposition, he is entitled to payment of an expert witness fee. In any case in which the court determines that a party has made a patently frivolous claim or a patently frivolous denial of liability, it shall order that all costs of the expert advisory panel be borne by the party making that claim or denial.

(f) Parties to the case, and counsel, may not communicate out of court with members of the panel on the subject matter of its inquiry and report, or cause or solicit others to do so, except through ordinary discovery proceedings.

(d) No discovery may be undertaken in a case until the report of the expert advisory panel is received. However, the court may relax this prohibition upon a showing of good cause by any party. If the panel has not completed its report within the 30-day period prescribed in (b) of this section, the court may, upon application, grant it an additional 30 days.

(e) The report of the panel and any dissenting or concurring opinion are admissible in evidence to the same extent as though its contents were orally testified to by the person or persons preparing it. The court shall delete any portion that would not be admissible because of lack of foundation for opinion testimony, or otherwise. Either party may submit expert testimony to support or refute the report. The jury shall be instructed in general terms that the report shall be considered and evaluated in the same manner as any other expert testimony. Any member of the panel may be called by any party and may be cross-examined as to the contents of the report or of his dissenting or concurring opinion.

(f) Members of a panel are entitled to travel expenses and per diem in accordance with state law pertaining to members of boards and commissions for all time spent in preparing its report and matters incidental to it. If a panel member is called upon as a witness at trial or upon deposition, he is entitled to payment of an expert witness fee. All expenses incurred by the panel shall be paid by the state. However, in any case in which the court determines that a party has made a patently frivolous claim or a patently frivolous denial of liability, it shall order that all costs of the expert advisory panel be borne by the party making that claim or denial.

(g) Parties to the case and their counsel may not initiate communication out of court with members of the panel on the subject matter of its inquiry and report or cause or solicit others to do so, except through ordinary discovery proceedings.

* Sec. 32. AS 09.55.540 is amended to read:

Sec. 09.55.540. BURDEN OF PROOF. (a) In a malpractice action based on the negligence or wilful misconduct of a health care provider [PHYSICIAN LICENSED UNDER AS 08.64, OR A DENTIST LICENSED UNDER AS 08.-36], the plaintiff has [SHALL HAVE] the burden of proving by a preponderance of the evidence

(1) the degree of knowledge or skill possessed or the degree of care ordinarily exercised under the circumstances, at the time of the act complained of, by health care providers in the field or specialty in which the defendant is practicing [BY PHYSICIANS OR DENTISTS PRACTICING THE SAME SPECIALTY IN SIMILAR COMMUNITIES TO THAT IN WHICH THE DEFENDANT PRACTICES];

(2) that the defendant either lacked this degree of knowledge or skill or failed to exercise this degree of care; and

(3) that as a proximate result of this lack of knowledge or skill or the failure to exercise this degree of care the plaintiff suffered injuries that would not otherwise have been incurred.

(b) In malpractice actions there is [SHALL BE] no presumption of negligence on the part of the defendant.

* Sec. 33. AS 09.55 is amended by adding new sections to read:

Sec. 09.55.546. ADVANCE PAYMENTS. In an action to recover damages under secs. 530 - 560 of this chapter, no advance payment made by the defendant health care provider or his professional liability insurer to or on behalf of the plaintiff may be admissible as evidence or may be construed as an admission of liability for injuries or damages suffered by the plaintiff; however, a final award in favor of the plaintiff shall be reduced to the extent of any advance payment. The advance payment shall inure to the exclusive benefit of the defendant or the insurer making the payment.

* Sec. 16. AS 09.55.540 is amended to read:

Sec. 09.55.540. BURDEN OF PROOF. (a) In a malpractice action based on the negligence or wilful misconduct of a health care provider [PHYSICIAN LICENSED UNDER AS 08.64, OR A DENTIST LICENSED UNDER AS 08.-36], the plaintiff has [SHALL HAVE] the burden of proving by a preponderance of the evidence

(1) the degree of knowledge or skill possessed or the degree of care ordinarily exercised under the circumstances, at the time of the act complained of, by health care providers in the field or specialty in which the defendant is practicing [BY PHYSICIANS OR DENTISTS PRACTICING THE SAME SPECIALTY IN SIMILAR COMMUNITIES TO THAT IN WHICH THE DEFENDANT PRACTICES];

(2) that the defendant either lacked this degree of knowledge or skill or failed to exercise this degree of care; and

(3) that as a proximate result of this lack of knowledge or skill or the failure to exercise this degree of care the plaintiff suffered injuries that would not otherwise have been incurred.

(b) In malpractice actions there is [SHALL BE] no presumption of negligence on the part of the defendant.

* Sec. 17. AS 09.55 is amended by adding a new section to read:

Sec. 09.55.547. AD DAMNUM. In a cause of action against a health care provider for malpractice, the complaint or any other pleadings may not contain an ad damnum clause or monetary amount claimed against the defendant health care provider, except as necessary for jurisdictional purposes.

Sec. 09.55.548. AWARDS, COLLATERAL SOURCE. (a) Damages shall be awarded in accordance with principles of the common law. The fact finder in a malpractice action shall render an award as to damages by category of loss. The court may enter a judgment that future damages be paid in whole or in part by periodic payments rather than by a lump-sum payment; the judgment shall include, if necessary, other provisions to assure that funds will be available as periodic payments become due. In this subsection, future damages includes damages for future medical treatment, care or custody, loss of future earnings, or loss of bodily function of the claimant.

(b) Except when the collateral source is a federal program which by law must seek subrogation and except death benefits paid under life insurance, a claimant may only recover damages from the defendant which exceed amounts received by the claimant as compensation for his injuries from collateral sources, whether private, group or governmental, and whether contributory or noncontributory. Evidence of collateral sources, other than a federal program which must by law seek subrogation and the death benefit paid under life insurance, is admissible after the fact finder has rendered an award, but the court shall also take into account the value of claimant's rights to coverage exhausted or depleted by payment of these collateral benefits. It may do so by adding back a reasonable estimate of their probable value, or by earmarking and holding for possible periodic payment under (a) of this section that amount of the award that would otherwise have been deducted, to see if the impairment of claimant's rights actually takes place in the future.

* Sec. 34. AS 09.55.550 is amended to read:

Sec. 09.55.550. JURY INSTRUCTIONS. In health care [MEDICAL] malpractice actions the jury shall be instructed that the plaintiff has the burden of proving [, BY A PREPONDERANCE OF THE EVIDENCE,] the health care provider's negligence or wilful misconduct in accordance with the standard of proof specified in sec. 540 of this chapter [OF THE PHYSICIAN OR DENTIST]. The jury shall be further instructed that injury alone does not raise a presumption of the health care provider's [PHYSICIAN'S OR DENTIST'S] negligence or misconduct.

* Sec. 35. AS 09.55 is amended by adding new sections to read:

Sec. 09.55.546. AWARDS, COLLATERAL SOURCES. (a) In a malpractice action damages shall be awarded according to the principles of the common law. The fact finder in rendering its award for damages shall specify the amount awarded for each category of loss, computing loss of future earnings on a monthly basis. The court may enter a judgment that future damages be paid in whole or in part by periodic payments rather than by a lump sum payment; however, any part of the award which is paid on periodic basis shall be increased annually in the same proportion as annual increases in the consumer price index for the community in which the claimant resides.

(c) Except when the collateral source is a federal program which by law must seek subrogation, an award to which a claimant is entitled may only cover damages which exceed any amounts received by the claimant as compensation for his injuries from collateral sources, whether private, group, or governmental, and whether contributory or noncontributory, except the death benefit paid under life insurance. Evidence of damages compensation by a collateral source, other than a federal program which must seek subrogation and the death benefit paid under life insurance, shall be credited against the award after the fact finder has rendered its award. Notwithstanding other provisions of state law and except as provided in this subsection, a collateral source does not have a right of subrogation.

* Sec. 18. AS 09.55.550 is amended to read:

Sec. 09.55.550. JURY INSTRUCTIONS. In health care [MEDICAL] malpractice actions the jury shall be instructed that the plaintiff has the burden of proving, by a preponderance of the evidence, the health care provider's negligence or wilful misconduct in accordance with sec. 540 of this chapter [OF THE PHYSICIAN OR DENTIST]. The jury shall be further instructed that injury alone does not raise a presumption of the health care provider's [PHYSICIAN'S OR DENTIST'S] negligence or misconduct.

* Sec. 19. AS 09.55 is amended by adding new sections to read:

Sec. 09.55.554. ORAL CONTRACTS. No cause of action against a health care provider arises for breach of an oral contract to provide a cure or achieve a specific medical result.

Sec. 09.55.556. INFORMED CONSENT. (a) A health care provider is liable for failure to obtain the informed consent of a patient if the claimant establishes by a preponderance of the evidence that the provider has failed to inform the patient of the common risks and reasonable alternatives to the proposed treatment or procedure, and that but for that failure the claimant would not have consented to the proposed treatment or procedure.

(b) It is a defense to any action for health care malpractice based upon an alleged failure to obtain informed consent that

(1) the risk not disclosed is too commonly known or is too remote to require disclosure;

(2) the patient stated to the health care provider that he would undergo the treatment or procedure regardless of the risk involved or that he did not want to be informed of the matters to which he would be entitled to be informed;

(3) under the circumstances consent by or on behalf of the patient was not possible; or

(4) the health care provider after considering all of the attendant facts and circumstances used reasonable discretion as to the manner and extent that the alternatives or risks were disclosed to the patient because he reasonably believed that a full disclosure would have a substantially adverse effect on the patient's condition.

Sec. 09.55.560. DEFINITIONS. In secs. 530 - 560 of this chapter "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital.

Sec. 09.55.556. INFORMED CONSENT. (a) A health care provider is liable for failure to obtain the informed consent of a patient if the claimant establishes by a preponderance of the evidence that the provider has failed to inform the patient of common risks and reasonable alternatives to the proposed treatment or procedure, and that, but for that failure, the claimant would not have consented to the proposed treatment or procedure.

(b) It is a defense to any action for health care malpractice based upon an alleged failure to obtain such an informed consent that

(1) the risk not disclosed is too commonly known or is too remote to require disclosure;

(2) the patient stated to the health care provider that he would undergo the treatment or procedure regardless of the risk involved, or that he did not want to be informed of the matters to which he would be entitled to be informed;

(3) under the circumstances consent by or on behalf of the patient was not possible; or

(4) the health care provider, after considering all of the attendant facts and circumstances, used reasonable discretion as to the manner and extent to which the alternatives or risks were disclosed to the patient because he reasonably believed that the manner and extent of such a disclosure would reasonably be expected to adversely and substantially affect the patient condition.

Sec. 09.55.560. DEFINITIONS. In secs. 530 - 560 of this chapter

(1) "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital;

(2) "panel" means an expert advisory panel established under sec. 536 of this chapter.

Sec. 36. AS 09.65.090 is repealed and re-enacted to read:

Sec. 09.65.090. CIVIL LIABILITY FOR EMERGENCY AID. (a) A person at a hospital or at any other location, who renders emergency care or emergency counseling to an injured, ill, or emotionally distraught person who reasonably appears to the person rendering the aid to be in immediate need of emergency aid in order to avoid serious harm or death is not liable for civil damages as a result of an act or omission in rendering emergency aid.

(b) This section does not preclude liability for civil damages as a result of gross negligence or reckless or intentional misconduct.

Sec. 37. AS 18.20 is amended by adding a new section to read:

Sec. 18.20.045. INSURANCE REQUIRED. (a) Every hospital, as a condition of licensure, shall [maintain] and submit to the department evidence of insurance against liability to inpatients and outpatients for malpractice issued by the Health Care Providers Indemnity Corporation, in amounts of not less than $200,000 per occurrence, and an aggregate liability per year of $1,000,000 minimum, and an additional $20,000 for each bed over 50.

(b) The director of insurance or his designee shall waive the requirement in (a) of this section for a hospital if the hospital furnishes satisfactory evidence of having other insurance providing coverage in amounts not less than those specified in (a) of this section. No waiver granted under this subsection may extend beyond the normal expiration date of the hospital's insurance policy or January 1, 1977, whichever occurs first.

Sec. 20. AS 09.65.090 is repealed and re-enacted to read:

Sec. 09.65.090. CIVIL LIABILITY FOR EMERGENCY AID. (a) A person, at a hospital or at any other location, who renders emergency care or emergency counseling to an injured, ill, or emotionally distraught person who reasonably appears to the person rendering the aid to be in immediate need of emergency aid in order to avoid serious harm or death is not liable for civil damages as a result of an act or omission in rendering emergency aid.

(b) This section does not preclude liability for civil damages as a result of gross negligence or reckless or intentional misconduct.

Sec. 21. AS 18.20 is amended by adding new sections to read:

Sec. 18.20.045. INSURANCE REQUIRED. Every hospital, as a condition of licensure, shall submit to the department and maintain evidence of insurance against liability to inpatients and outpatients for malpractice issued by the Health Care Providers Indemnity Corporation, in amounts of not less than $200,000 per occurrence, and an aggregate liability per year of $1,000,000 minimum, and an additional $20,000 for each bed over 50 for which the hospital is licensed.

Sec. 18.20.075. RISK MANAGEMENT. (a) To be eligible for a license each hospital shall have in operation an internal risk management program which shall

(1) investigate the frequency and causes of adverse incidents in hospitals which cause injury to patients;

(2) develop and implement measures to minimize the risk of injury to patients from adverse incidents; in developing these measures each hospital shall take into account recommendations of the Health Care Providers Indemnity Corporation, its medical staff, private underwriters, industry standards, experience of other hospitals, and recommendations of licensing boards of other health care providers; and

(3) analyze patient grievances which relate to patient care.

(b) The department shall adopt by regulation and submit to the legislative administrative regulation review committee prior to implementation standards for risk management programs in hospitals in the state which may vary according to the size of the hospital, the type of care offered by the hospital, and other factors found relevant by the department.




* Sec. 38. AS 18 is amended by adding a new chapter to read:

CHAPTER 23. HEALTH CARE SERVICES INFORMATION.

Sec. 18.23.010. LIMITATION OF LIABILITY FOR PERSONS PROVIDING INFORMATION TO REVIEW ORGANIZATION. (a) No person providing information to a review organization is subject to action for damages or other relief by reason of having furnished that information, unless the information is false and the person providing the information knew or had reason to know the information was false.

(b) No privilege of confidentiality arising from a physician-patient relationship may be invoked to withhold pertinent information from review by a review organization.

Sec. 18.23.020. LIMITATION ON LIABILITY FOR MEMBERS OF REVIEW ORGANIZATIONS. No person who is a member or employee of, or who acts in an advisory capacity to, or who furnishes counsel or services to a review organization is liable for damages or other relief in an action brought by another whose activities have been or are being scrutinized or reviewed by a review organization, by reason of the performance of a duty, function or activity of the review organization, unless the performance of the duty, function or activity was motivated by malice toward the affected person. No person is liable for damages or other relief in an action by reason of his performance of a duty, function, or activity as a member of a review organization or by reason of a recommendation or action of the review organization when the person acts in the reasonable belief that the action or recommendation is warranted by facts known to the person or to the review organization after reasonable efforts to ascertain the facts upon which the review organization's action or recommendation is made.

Sec. 18.23.030. CONFIDENTIALITY OF RECORDS OF REVIEW ORGANIZATION. (a) Except as provided in (b) of this section, all data and information acquired by a review organization, in the exercise of its duties and functions, shall be held in confidence and may not be disclosed to anyone except to the extent necessary to carry out the purposes of the review organization, and is not subject to subpoena or discovery.

Except as provided in (b) of this section, no person described in sec. 20 of this chapter may disclose what transpired at a meeting of a review organization except to the extent necessary to carry out the purposes of a review organization, and the proceedings and records of a review organization are not subject to discovery or introduction into

* Sec. 22. AS 18 is amended by adding a new chapter to read:

CHAPTER 23. HEALTH CARE SERVICES INFORMATION.

Sec. 18.23.010. LIMITATION ON LIABILITY FOR PERSONS PROVIDING INFORMATION TO REVIEW ORGANIZATION. (a) No person providing information to a review organization is subject to action for damages or other relief by reason of having furnished that information, unless the information is false and the person providing the information knew or had reason to know the information was false.

(b) No privilege of confidentiality arising from a physician-patient relationship may be invoked to withhold pertinent information from review by a review organization.

Sec. 18.23.020. LIMITATION ON LIABILITY FOR MEMBERS OF REVIEW ORGANIZATIONS. No person who is a member or employee of, or who acts in an advisory capacity to, or who furnishes counsel or services to, a review organization is liable for damages or other relief in an action brought by a person whose activities have been or are being scrutinized or reviewed by a review organization, by reason of his performance of a duty, function or activity of the review organization, unless the performance of the duty, function or activity was motivated by malice toward the affected person. No person is liable for damages or other relief in an action by reason of his performance of a duty, function, or activity as a member of a review organization or by reason of a recommendation or action of the review organization when the person acts in the reasonable belief that his action or recommendation is warranted by facts known to him or to the review organization after reasonable efforts to ascertain the facts upon which the review organization's action or recommendation is made.

Sec. 18.23.030. CONFIDENTIALITY OF RECORDS OF REVIEW ORGANIZATION. (a) Except as provided in (b) of this section, all data and information acquired by a review organization, in the exercise of its duties and functions, shall be held in confidence, may not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review organization, and is not subject to subpoena or discovery. Except as provided in (b) of this section, no person described in sec. 20 of this chapter may disclose what transpired at a meeting of a review organization except to the extent necessary to carry out one or more of the purposes of a review organization, and the proceedings and records of a review organization are not subject to discovery or introduction into evidence in a civil action against a health care provider arising

INFORMATION TO REVIEW ORGANIZATION. (a) No person providing information to a review organization is subject to action for damages or other relief by reason of having furnished that information, unless the information is false and the person providing the information knew or had reason to know the information was false.

(b) No privilege of confidentiality arising from a physician-patient relationship may be invoked to withhold pertinent information from review by a review organization.

Sec. 18.23.020. LIMITATION ON LIABILITY FOR MEMBERS OF REVIEW ORGANIZATIONS. No person who is a member or employee of, or who acts in an advisory capacity to, or who furnishes counsel or services to a review organization is liable for damages or other relief in an action brought by another whose activities have been or are being scrutinized or reviewed by a review organization, by reason of the performance of a duty, function or activity of the review organization, unless the performance of the duty, function or activity was motivated by malice toward the affected person. No person is liable for damages or other relief in an action by reason of his performance of a duty, function, or activity as a member of a review organization or by reason of a recommendation or action of the review organization when the person acts in the reasonable belief that the action or recommendation is warranted by facts known to the person or to the review organization after reasonable efforts to ascertain the facts upon which the review organization's action or recommendation is made.

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Except as provided in (b) of this section, no person described in sec. 20 of this chapter may disclose what transpired at a meeting of a review organization except to the extent necessary to carry out the purposes of a review organization, and the proceedings and records of a review organization are not subject to discovery or introduction into evidence in a civil action against a health care provider arising out of the matter which is the subject of consideration by the review organization. Information, documents, or records otherwise available from original sources are not immune from discovery or use in a civil action merely because they were presented during proceedings of a review organization, nor may a person who testified before a review organization or who is a member of it be prevented from testifying as to matters within his knowledge, but a witness may not be asked about his testimony before a review organization or opinions formed by him as a result of its hearings, except as provided in (b) of this section.

INFORMATION TO REVIEW ORGANIZATION. (a) No person providing information to a review organization is subject to action for damages or other relief by reason of having furnished that information, unless the information is false and the person providing the information knew or had reason to know the information was false.

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Sec. 18.23.020. LIMITATION ON LIABILITY FOR MEMBERS OF REVIEW ORGANIZATIONS. No person who is a member or employee of, or who acts in an advisory capacity to, or who furnishes counsel or services to, a review organization is liable for damages or other relief in an action brought by a person whose activities have been or are being scrutinized or reviewed by a review organization, by reason of his performance of a duty, function or activity of the review organization, unless the performance of the duty, function or activity was motivated by malice toward the affected person. No person is liable for damages or other relief in an action by reason of his performance of a duty, function, or activity as a member of a review organization or by reason of a recommendation or action of the review organization when the person acts in the reasonable belief that his action or recommendation is warranted by facts known to him or to the review organization after reasonable efforts to ascertain the facts upon which the review organization's action or recommendation is made.

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Sec. 18.23.030. CONFIDENTIALITY OF RECORDS OF REVIEW ORGANIZATION. (a) Except as provided in (b) of this section, all data and information acquired by a review organization, in the exercise of its duties and functions, shall be held in confidence, may not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review organization, and is not subject to subpoena or discovery. Except as provided in (b) of this section, no person described in sec. 20 of this chapter may disclose what transpired at a meeting of a review organization except to the extent necessary to carry out one or more of the purposes of a review organization, and the proceedings and records of a review organization are not subject to discovery or introduction into evidence in a civil action against a health care provider arising out of the matter which is the subject of consideration by the review organization. Information, documents, or records otherwise available from original sources are not immune from discovery or use in a civil action merely because they were presented during proceedings of a review organization, nor may a person who testified before a review organization or who is a member of it be prevented from testifying as to matters within his knowledge, but a witness may not be asked about his testimony before a review organization or opinions formed by him as a result of its hearings, except as provided in (b) of this section.

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adduced before a review organization that are otherwise inaccessible under this section may be obtained by a health care provider who claims that denial is unreasonable, or may be obtained under subpoena or discovery proceedings brought by a plaintiff who claims that information provided to a review organization was false and claims that the person providing the information knew or had reason to know the information was false.

(c) Nothing in this chapter prevents a person whose conduct or competence has been reviewed under this chapter from obtaining, for the purpose of appellate review of the action of the review organization, any testimony, documents, proceedings, records and other evidence adduced before the review organization.

Sec. 18.23.040. PENALTY FOR VIOLATION. Other than as authorized by sec. 30 of this chapter, a disclosure of data and information acquired by a review committee or of what transpired at a review meeting is a misdemeanor and punishable under AS 11.05.010.

Sec. 18.23.050. PROTECTION OF PATIENT. Nothing in this chapter relieves a person of liability which he has incurred or may incur to a person as a result of furnishing health care to the patient.

Sec. 18.23.060. PARTIES BOUND BY REVIEW. When a review organization reviews matters under sec. 70(5)(H) of this chapter no party is bound by a ruling of the organization in a controversy, dispute or question unless he agrees in advance, either specifically or generally, to be bound by the ruling.

Sec. 18.23.070. DEFINITIONS. In this chapter, unless the context otherwise requires,

(1) "administrative staff" means the staff of a hospital or clinic;

(2) "health care" means professional services rendered by a health care provider or an employee of a health care provider, and services furnished by a sanatorium, rest home, nursing home, boarding home or other institution for the hospitalization or care of human beings;

(3) "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital;

adduced before a review organization that are otherwise inaccessible under this section may be obtained by a health care provider who claims that denial is unreasonable or may be obtained under subpoena or discovery proceedings brought by a plaintiff who claims that information provided to a review organization was false and claims that the person providing the information knew or had reason to know the information was false.

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(4) "professional service" means service rendered by a health care provider of the type he is licensed to render;

(5) "review organization" means a hospital governing body or a committee whose membership is limited to health care providers and administrative staff, except where otherwise provided for by state or federal law, and which is established by a hospital, by a clinic, by one or more state or local associations of health care providers, by an organization of health care providers from a particular area or medical institution, or by a professional standards review organization established under 42 U.S.C., sec. 1320c-1 et seq., to gather and review information relating to the care and treatment of patients for the purposes of

(A) evaluating and improving the quality of health care rendered in the area or medical institution;

(B) reducing morbidity or mortality;

(C) obtaining and disseminating statistics and information relative to the treatment and prevention of diseases, illness and injuries;

(D) developing and publishing guidelines showing the norms of health care in the area or medical institution;

(E) developing and publishing guidelines designed to keep the cost of health care within reasonable bounds;

(F) reviewing the quality or cost of health care services provided to enrollees of health maintenance organizations;

(G) acting as a professional standards review organization under 42 U.S.C., sec. 1320c-1 et seq.;

(H) reviewing, ruling on, or advising on controversies, disputes or questions between

(i) a health insurance carrier or health maintenance organization and one or more of its insured or enrollees;

(ii) a professional licensing board, acting under its powers of discipline or license revocation or suspension, and a health care provider licensed by it when the matter is referred to a review organization by the professional licensing board;

(iii) a health care provider and his patients concerning diagnosis, treatment or care, or a charge or fee;

(iv) a health care provider and a health insurance carrier or health maintenance organization concerning a charge or fee for health care services provided to an insured or enrollee; or

(4) "professional service" means service rendered by a health care provider of the type he is licensed to render;

(5) "review organization" means a hospital governing body or a committee whose membership is limited to health care providers and administrative staff, except where otherwise provided for by state or federal law, and which is established by a hospital, by a clinic, by one or more state or local associations of health care providers, by an organization of health care providers from a particular area or medical institution, or by a professional standards review organization established under 42 U.S.C., sec. 1320(c)(1) et seq., to gather and review information relating to the care and treatment of patients for the purposes of

(A) evaluating and improving the quality of health care rendered in the area or medical institution;

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(C) obtaining and disseminating statistics and information relative to the treatment and prevention of diseases, illness and injuries;

(D) developing and publishing guidelines showing the norms of health care in the area or medical institution;

(E) developing and publishing guidelines designed to keep the cost of health care within reasonable bounds;

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(i) a health insurance carrier or health maintenance organization and one or more of its insured or enrollees;

(ii) a professional licensing board, acting under its powers of discipline or license revocation or suspension, and a health care provider licensed by it when the matter is referred to a review organization by the professional licensing board;

(iii) a health care provider and his patients concerning diagnosis, treatment or care, or a charge or fee;

(iv) a health care provider and a health insurance carrier or health maintenance organization concerning a charge or fee for health care services provided to an insured or enrollee; or

federal or a state or local government, or an agency of the federal or a state or local government;

(I) acting on the recommendation of a credential review committee or a grievance committee.

* Sec. 39. AS 21 is amended by adding a new chapter to read:

CHAPTER 88. HEALTH CARE PROVIDERS INSURANCE.

ARTICLE 1. PURPOSE.

Sec. 21.88.010. PURPOSE OF CHAPTER. It is the purpose of this chapter to provide a means of furnishing health care providers with adequate insurance against liability for medical negligence by concentrating all such insurance in one entity which can negotiate more successfully for insurance from casualty insurers and to distribute equitably the true cost of the insurance among the health care providers insured.

ARTICLE 2. INDEMNITY CORPORATION.

Sec. 21.88.020. CORPORATION CREATED. There is created the Alaska Health Care Providers Indemnity Corporation which is a public corporation having a legal existence independent of and separate from the state. Obligations issued by the corporation do not constitute a debt, liability or obligation of the state or a pledge of full faith and credit of the state.

Sec. 21.88.030. CORPORATION BOARD OF GOVERNORS. (a) The corporation shall exercise its powers through a board of governors which shall be appointed by the governor of the state and confirmed by the legislature as provided in (b) of this section.

(b) The appointments to the board of governors shall be Alaska residents as follows:

(1) two physicians licensed in the state; one of the physicians shall be engaged in group practice in a clinic of six or more physicians;

(2) one person employed by a hospital or on the board of directors of a hospital;

(3) two professionals in the insurance field;

(4) two persons who are not health care providers or financially interested in the field of health care, attorneys, or representatives of the insurance industry.

(c) The term of office of each governor is three years, except that the governor of the state shall designate two initially appointed governors to serve for one year and two initially appointed governors to serve for two years.

(d) Upon the expiration of the term of a governor, the governor of the state shall appoint a successor who shall be from the same class described in (b) of this section as the governor whose term has expired.

(e) Upon a governor's early resignation, death or inability to

federal or a state or local government, or an agency of the federal or a state or local government;

(I) acting on the recommendation of a credential review committee or a grievance committee.

* Sec. 23. AS 21 is amended by adding a new chapter to read:

CHAPTER 88. HEALTH CARE PROVIDERS INSURANCE.

ARTICLE 1. PURPOSE.

Sec. 21.88.010. PURPOSE OF CHAPTER. It is the purpose of this chapter to provide a means of assuring all health care providers continuous, affordable and adequate insurance against liability for medical negligence by concentrating all such insurance in one entity and to distribute equitably the cost of the insurance among the health care providers insured.

ARTICLE 2. INDEMNITY CORPORATION.

Sec. 21.88.020. CORPORATION CREATED. There is created the Alaska Health Care Providers Indemnity Corporation which is a public corporation having a legal existence independent of and separate from the state. Obligations issued by the corporation do not constitute a debt liability or obligation of the state or a pledge of full faith and credit of the state.

Sec. 21.88.030. CORPORATION BOARD OF GOVERNORS. (a) The corporation shall exercise its powers through a board of governors which shall be appointed by the director as provided in (b) of this section.

(b) The appointments to the board of governors shall be Alaska residents as follows:

(1) two members of the Alaska State Medical Association appointed from a list of no less than five persons recommended by the governing board of that association; one of the members appointed shall be engaged in group practice in a clinic of six or more physicians licensed in the state;

(2) one member of the Alaska State Hospital Association appointed from a list of no less than three persons recommended by the governing board of that association;

(3) two professionals in the insurance field;

(4) two persons who are neither health care providers nor affiliated with the insurance industry.

(c) The term of office of each governor is three years, except that the director shall designate three initially appointed governors to serve for one year and two initially appointed governors to serve for two years.

(d) Upon the expiration of the term of a governor, the director shall appoint a successor who shall be from the same class described in (b) of this section as the governor whose term has expired.

(e) Upon a governor's early resignation, death or inability to

serve, the governor of the state shall appoint a successor from the same class defined in (b) of this section as the terminating governor, who shall serve for the unexpired term.

(f) The director or his designee is not a voting member of the board of governors but shall be notified by the board of and have the right to attend and participate in all meetings and proceedings of the board.

(g) Each member of the board of governors shall be allowed compensation for services and reimbursement for reasonable expenses incurred in attending meetings of the board and transacting corporation business, as set out in the plan of operation.

Sec. 21.88.040. CORPORATION PLAN OF OPERATION. (a) Within 30 days after the effective date of this chapter, the board of governors shall prepare and submit to the director for approval a plan of operation which provides for the fair, reasonable and equitable administration of the affairs of the corporation and the discharge of the purposes for which it is created. The plan and any amendments of it become effective upon the director's approval. If the board of governors fails to submit a plan of operation, or if at a subsequent time the board of governors fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate a plan of operation or amendments which are necessary or advisable to effectuate the provisions of this chapter. Adoption of the plan is not subject to the Administrative Procedure Act (AS 44.62).

(b) The plan of operation shall

(1) establish the procedures by which all the powers and duties of the corporation specified in sec. 50 of this chapter shall be performed;

(2) establish procedures for handling assets and discharging liabilities of the corporation;

(3) establish regular places and times for meetings of the board of governors;

(4) establish procedures for records to be kept of all financial transactions of the corporation, its agents, and the board of governors;

(5) establish the amount and method of reimbursing and compensating members of the board of governors;

(6) establish the procedures for awarding contracts to indemnify or defend or to provide other services and to compensate the indemnitors or vendors;

(7) establish the procedures for issuing contracts of insurance as provided in sec. 50 of this chapter and for the determination of rates;

(8) contain additional provisions necessary or proper for

defined in (b) of this section as the terminating governor, who shall serve for the unexpired term.

(f) The director or his designee is not a voting member of the board of governors but shall be notified by the board of and have the right to attend and participate in all meetings and proceedings of the board.

(g) Members of the board of governors receive compensation from the corporation of $100 per day when the board meets and necessary travel expenses.

Sec. 21.88.040. CORPORATION PLAN OF OPERATION. (a) Within 30 days after the effective date of this chapter, the board of governors shall prepare and submit to the director for approval a plan of operation which provides for the fair, reasonable and equitable administration of the affairs of the corporation and the discharge of the purposes for which it is created. The plan and any amendments of it become effective upon the director's approval. If the board of governors has failed to submit a plan of operation, or if at any subsequent time the board of governors fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate a plan of operation or amendments which are necessary or advisable to effectuate the provisions of this chapter. Adoption of the plan is not subject to the Administrative Procedure Act (AS 44.62).

(b) The plan of operation shall

(1) establish the procedures by which all the powers and duties of the corporation specified in sec. 50 of this chapter shall be performed;

(2) establish procedures for handling assets and discharging liabilities of the corporation;

(3) establish regular places and times for meetings of the board of governors;

(4) establish procedures for records to be kept of all financial transactions of the corporation, its agents, and the board of governors;

(5) establish procedures for awarding contracts to carry out the provisions of this chapter;

(6) establish the procedures for issuing contracts of insurance as provided in sec. 50 of this chapter and for the determination of rates;

(7) contain additional provisions necessary or proper for the execution of the powers and duties of the corporation.

Sec. 21.88.050. POWERS AND DUTIES OF THE CORPORATION. (a) The corporation shall

(1) in the form approved by the director, issue to all health care providers who pay the premiums for it a contract or contracts indemnifying the health care provider and his employees who are health care providers against loss by reason of liability for professional services on an occurrence basis and agreeing to tender on behalf of the health care provider and his employees who are health care providers a defense in a proceeding brought under AS 09.55.530 - 09.55.560; the limit of liability shall be no less than the minimum liability coverage requirements to be maintained under AS 08.64.215 and AS 18.20.045; the contract shall cover the defense against but need not indemnify a claim for punitive damages; at the option of the health care provider and for an additional premium the contract may cover claims against the health care provider that arise out of professional services performed by the health care provider after December 31, 1974 except that coverage will not be provided for a claim already filed or of which the health care provider had or reasonably should have had notice at the time the retroactive insurance was purchased;

(2) charge a premium for the protection provided by the contracts issued under (1) of this subsection which shall be determined by the board of governors in accordance with sec. 80 of this chapter and subject to the approval of the director;

(3) negotiate for and procure reinsurance from a casualty insurers or reinsurers for all of its liability incurred by contracts issued under (1) of this subsection; the corporation may not incur or retain under those contracts liability which is not reinsured as provided in this paragraph; if, after the exercise of due diligence, no reinsurance for all or a portion of the risk can be procured at reasonable rates from casualty insurers or reinsurers, the corporation through the board of governors, shall so certify to the director reinsurance shall then be provided by the Health Care Joint Underwriting Association as provided in sec. 110 et seq. of this chapter for that portion not reinsured by a private carrier;

(4) comply with or be subject to AS 21.06.090; 21.06.120; 21.06.140; 21.06.160; 21.06.250; AS 21.09.180; 21.09.190; 21.09.200; 21.09.250; 21.09.280; AS 21.12.020(b), (c), (d), and (e); and chs. 18, 21, 24, and 36 of this title;

Sec. 21.88.050. POWERS AND DUTIES OF THE CORPORATION. (a) The corporation shall

(1) issue to all health care providers who pay the premiums for it a contract on an occurrence basis indemnifying the health care provider and his employees who are health care providers against loss by reason of liability and agreeing to tender on behalf of the health care provider and his employees who are health care providers a defense of the health care provider in a proceeding brought under AS 09.55.530 - 09.55.560; the limit of liability shall be no less than the minimum liability coverage required to be maintained as stated in AS 08.64.215 and AS 18.20.045; the contract shall cover the defense against but need not indemnify a claim for punitive damages; the contract shall cover claims against health care providers

(A) that arise out of professional services performed by the health care provider during the period for which the premium is paid; and

(B) at the option of the health care provider and for an additional premium, that arise out of services performed by the health care provider after December 31, 1974 for any period in which the health care provider had no malpractice insurance, except that coverage will not be provided for a claim already filed or of which the health care provider has or reasonably should have had notice at the time retroactive insurance was purchased;

(2) charge a premium for the protection provided by the contracts issued under (1) of this subsection which shall be determined by the board of governors in accordance with sec. 70 of this chapter and subject to the approval of the director;

(3) comply with or be subject to AS 21.06.090, 21.06.120, 21.06.140, 21.06.160, 21.06.250; AS 21.09.180, 21.09.190, 21.09.200, 21.09.250, 21.09.280; AS 21.12.020(b), (c), (d), and (e); and chs. 18, 21, 24, and 36 of this title;

(5) carry out the obligations of the contracts issued under (1) of this subsection by defending all covered claims made against insured health care providers and by paying all liabilities which are finally adjudicated against the insured health care provider or which may in the opinion of the corporation reasonably be expected to be finally adjudicated against the health care provider to the extent of the contract obligation;

(6) provide coverage to health care providers for liability in excess of the minimum limits required for licensure as a health care provider, but limited to $1,000,000 for individual health care providers and $5,000,000 for hospitals, if there is a finding by the director that this coverage is unavailable at a reasonable cost and that this coverage can be made available at a reasonable cost through the corporation; if this paragraph is implemented, then each health care provider obtaining excess coverage up to these amounts shall obtain it from the corporation.

(b) The corporation may

(1) in the form approved by the director, issue contracts of professional liability insurance to chiropractors licensed under AS 08.20, dental hygienists licensed under AS 08.32, dentists licensed under AS 08.36, nurses licensed under AS 08.68, dispensing opticians licensed under AS 08.71, optometrists licensed under AS 08.72, pharmacists licensed under AS 08.80, physical therapists licensed under AS 08.84, and pyschologists and psychological associates licensed under AS 08.86;

(2) employ or retain persons, individual or corporate, to discharge its obligations and pay reasonable compensation for those services; employees of the corporation are not considered state employees;

(3) provide coverage to health care providers for other hazards where there is a finding by the director that this coverage is otherwise unavailable by reason of the operation of the corporation;

(4) borrow or advance funds necessary to effectuate the

purposes of the corporation;

(5) negotiate and become a party to those contracts as are necessary to carry out the purposes of the corporation;

(6) sue or be sued in the name of the corporation;

(4) carry out the obligations of the contracts issued under (1) of this subsection by defending all covered claims made against insured health care providers and by paying all liabilities which are finally adjudicated against the insured health care provider or which may in the opinion of the corporation reasonably be expected to be finally adjudicated against the health care provider to the extent of the contract obligation;

(5) provide coverage to health care providers for liability under AS 09.55.530 - 09.55.560 in excess of the minimum limits required for licensure a[illegible]lth care provider, but limited to $1,000,000 for individual health [illegible] providers and $5,000,000 for hospitals, if there is a finding by the director that this coverage is unavailable at a reasonable cost and that this coverage can be made available at a reasonable cost through the corporation; if this paragraph is implemented, each health care provider obtaining excess coverage up to these amounts shall obtain it from the corporation, and the corporation may procure reinsurance for all the risks incurred by contracts issued under this paragraph from the private market.

(b) The corporation may

(1) employ or retain persons, individual or corporate, to discharge its obligations and shall pay, by way of salary, wage, fee, or commission, reasonable compensation for those services; employees of the corporation are not considered state employees;

(2) provide coverage to health care providers for other hazards including malpractice liability insurance for other licensed health care providers employed by the physician or hospital;

(3) borrow funds from the revolving loan fund established under sec. 110 of this chapter when necessary for the corporation to maintain adequate reserves; loans from the fund shall be repaid from prospective premium increases within four years after the loan is made at an annual interest rate of seven per cent;

(4) negotiate and become a party to those contracts as are necessary to carry out the purposes of the corporation;

(5) sue or be sued in the name of the corporation;

(6) negotiate and become a party to contracts for management services for the corporation;

(7) perform all other acts necessary and proper to effectuate the corporation.

Sec. 21.88.060. PREMIUM TAX. The corporation shall pay a premium tax in the amount of one and one-half per cent of the total direct premium income received by the corporation during the year ending on the preceding December 31, after deducting the applicable cancellations, returned premium, the unabsorbed portion of any deposit premiums, all policy dividends, unabsorbed premiums refunded to policyholders, refunds, savings, savings coupons and other similar returns paid or credited to policyholders with respect to their policies. The tax shall be paid to the director annually before April 1 of each year.

Sec. 21.88.070. STATISTICS. The corporation shall collect, maintain and report information concerning claims against health care providers. The information shall be on forms prescribed by the director, and shall be sufficient to enable a proper determination of losses for rate making and to identify causes and sources of loss for loss control. At least annually the corporation shall report to the director the number and amount of claims filed, reserved, paid, settled and adjudicated during the year, the premiums paid to and the expenses incurred by the corporation during the year. This report shall be available to the public. The director may require that supplemental reports include the names of insured health care providers and the claimants; however, no reports which become publicly available may include the names of health care providers or claimants or information that will permit by inference the identity of specific health care providers or claimants. All statistics shall be made available to the appropriate licensing board or agency.

Sec. 21.88.080. RATES. (a) The rates and rating plans used by the corporation for the policies issued shall be determined by license category of health care providers in accordance with all of the following:

(1) rates may not be excessive; rates are excessive if, after a period of time and with respect to an amount of gross premium which are actuarially credible, the premiums exceed losses incurred by the corporation, including losses paid, reserves for claims reported and unpaid, reserves for claims incurred during the policy period and not reported, provided that reserves for claims incurred during the policy period and reasonably expected to be reported after three years after

(7) provide risk management advice and services to hospitals;

(8) perform all other acts necessary and proper to effectuate the corporation.

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Sec. 21.88.060. STATISTICS. The corporation shall collect, maintain and report information concerning claims against health care providers. All such information shall be on forms prescribed by the director and shall be sufficient to enable a proper determination of losses for rate making and to identify causes and sources of loss for loss control. No less often than annually the corporation shall report to the director, which report shall be kept available to the public, the number and amount of claims filed, reserved, paid, settled and adjudicated during the year, the premiums paid to, and the expenses incurred by the corporation during the year. The director may require that supplemental reports include the names of insured health care providers and the claimants; however, no reports which become publicly available may include the names of health care providers or claimants or information that will permit by inference the identity of specific health care providers or claimants. All information shall be made available to the appropriate licensing boards or agencies.

Sec. 21.88.070. RATES. Rates and rating plans used by the corporation for the policies issued shall be determined for each category of health care provider in accordance with all of the following:

(1) rates for physicians shall be set as a function of the physician's medical revenue;

(2) rates for hospitals shall be set as a function of the number of permanent beds in the hospital;

(3) a minimum rate may be set for each category of health care provider or discipline or classification within the license category;

(4) rates may not be excessive; rates are excessive if, after a period of time and with respect to an amount of gross premium which are actuarially credible, the premiums exceed losses incurred by the corporation, including losses paid, reserves for claims reported and unpaid, reserves for claims incurred during the policy period and not reported but reasonably expected to be reported within three years after the date of the incident, and reasonable expenses for the operation of

tor, and shall be sufficient to enable a proper determination of losses for rate making and to identify causes and sources of loss for loss control. At least annually the corporation shall report to the director the number and amount of claims filed, reserved, paid, settled and adjudicated during the year, the premiums paid to and the expenses incurred by the corporation during the year. This report shall be available to the public. The director may require that supplemental reports include the names of insured health care providers and the claimants; however, no reports which become publicly available may include the names of health care providers or claimants or information that will permit by inference the identity of specific health care providers or claimants. All statistics shall be made available to the appropriate licensing board or agency.

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Sec. 21.88.080. RATES. (a) The rates and rating plans used by the corporation for the policies issued shall be determined by license category of health care providers in accordance with all of the following:

(1) rates may not be excessive; rates are excessive if, after a period of time and with respect to an amount of gross premium which are actuarially credible, the premiums exceed losses incurred by the corporation, including losses paid, reserves for claims reported and unpaid, reserves for claims incurred during the policy period and not reported, provided that reserves for claims incurred during the policy period and reasonably expected to be reported after three years after the incident may be included on a different basis due to the additional financial flexibility provided by the corporation, and reasonable expenses for the operation of the corporation;

director and shall be sufficient to enable a proper determination of losses for rate making and to identify causes and sources of loss for loss control. No less often than annually the corporation shall report to the director, which report shall be kept available to the public, the number and amount of claims filed, reserved, paid, settled and adjudicated during the year, the premiums paid to, and the expenses incurred by the corporation during the year. The director may require that supplemental reports include the names of insured health care providers and the claimants; however, no reports which become publicly available may include the names of health care providers or claimants or information that will permit by inference the identity of specific health care providers or claimants. All information shall be made available to the appropriate licensing boards or agencies.

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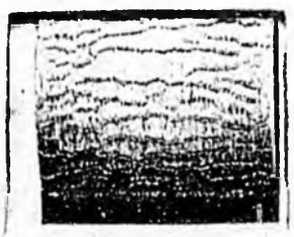
Sec. 21.88.070. RATES. Rates and rating plans used by the corporation for the policies issued shall be determined for each category of health care provider in accordance with all of the following:

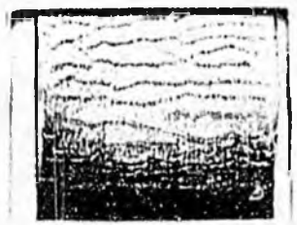
(1) rates for physicians shall be set as a function of the physician's medical revenue;

(2) rates for hospitals shall be set as a function of the number of permanent beds in the hospital;

(3) a minimum rate may be set for each category of health care provider or discipline or classification within the license category;

(4) rates may not be excessive; rates are excessive if, after a period of time and with respect to an amount of gross premium which are actuarially credible, the premiums exceed losses incurred by the corporation, including losses paid, reserves for claims reported and unpaid, reserves for claims incurred during the policy period and not reported but reasonably expected to be reported within three years after the date of the incident, and reasonable expenses for the operation of the corporation;





(2) rates shall not be inadequate; rates are inadequate if, based on available actuarial data, the premiums to be paid by the health care providers are or may reasonably be expected to be insufficient to pay for losses incurred by the corporation, including claims paid, reserves for claims reported and unpaid, reserves for claims incurred during the policy period and not reported provided that reserves for claims incurred during the policy period and reasonably expected to be reported after three years after the incident may be included on a different basis due to the additional financial flexibility provided by the corporation, and reasonable expenses for the operation of the corporation;

p.31

(3) rates may not be unfairly discriminatory;

(4) rates shall be adjusted annually;

(5) rates for any policy year shall be calculated to include the adjustment for actual experience of the corporation;

(6) in considering losses to be incurred, changes in the law, national, regional or local trends in medical negligence awards, and other relevant factors may be considered;

(7) income from the investment of reserves shall be considered;

(8) individual risk underwriting factors shall be considered.

Note

(b) The standards in (a) of this section shall be applied to the policy forms the corporation decides to write.

Sec. 21.88.090. REQUIRED INSURANCE; CANCELLATION. The corporation shall provide insurance to all health care providers otherwise eligible for licensure under AS 08.64 and AS 18.20. The corporation may provide for installment payment of premiums in which event each installment is due by the date specified. The corporation may cancel any of its policies in the event of nonpayment of any premium or installment on a premium, or other charge, by mailing or delivering to the insured at the address shown on the policy and to the agency of the state issuing the insured's license written notice stating when, not less than 10 days after notice is received by the insured, the cancellation is effective.

ARTICLE 3. JOINT UNDERWRITING ASSOCIATION.

Sec. 21.88.110. ASSOCIATION CREATED. (a) The Health Care Providers Joint Underwriting Association is created consisting of all licensed

(1) health care service corporations as defined in AS 21.87.330;

(2) disability insurers as defined in AS 21.12.050;

(3) property insurers as defined in AS 21.12.060; and

(4) casualty insurers as defined in AS 21.12.070.

(5) rates may not be inadequate; rates are inadequate if, based on available actuarial data, the premiums to be paid by the health care providers are or may reasonably be expected to be insufficient to pay for losses incurred by the corporation, including claims paid, reserves for claims reported and unpaid, reserves for claims incurred during the policy year and not reported but reasonably expected to be reported within three years after the date of the incident, and reasonable expenses for the operation of the corporation;

p.30

(6) rates shall be adjusted at least as often as annually;

(7) rates for any policy year shall be calculated to include the adjustment for actual experience of the corporation as developed for the preceding four policy years;

(8) in considering losses to be incurred, changes in the law and national, regional and local trends in medical negligence awards may be considered;

p.28

(9) income from investment of reserves shall be considered;

(10) disciplines and classifications within the license categories of health care providers shall be considered;

(11) individual risk underwriting factors shall be considered;

(12) amounts sufficient to repay loan obligations shall be considered.

Sec. 21.88.080. REQUIRED INSURANCE; CANCELLATION. The corporation shall provide insurance to all health care providers otherwise eligible for licensure under AS 08.64 and AS 18.20. The corporation may provide for installment payment of premiums in which event each installment is due by the date specified. The corporation may cancel any of its policies in the event of nonpayment of any premium or installment on a premium or other charge by mailing or delivering to the insured at the address shown on the policy and to the agency of the state issuing the insured's license written notice stating when, not less than 10 days after notice is received by the insured, the cancellation is effective.

ARTICLE 3. LOAN FUND.

Sec. 21.88.110. FUND ESTABLISHED. (a) There is in the Department of Commerce and Economic Development a medical malpractice liability revolving loan fund to be administered by the director of insurance.

(b) Loans shall be made from the fund to the corporation upon certification by the director that a loan is necessary for the corporation to maintain adequate reserves or for initial costs of operation. If a loan is made to the corporation from the fund, the corporation shall issue a note to the fund pledging the premiums collected in the future as security for the loan.

(8) individual risk underwriting factors shall be consider[illegible]

(b) The standards in (a) of this section shall be applied to the policy terms the corporation decides to write.

Sec. 21.88.090. REQUIRED INSURANCE; CANCELLATION. The corporation shall provide insurance to all health care providers otherwise eligible for licensure under AS 08.64 and AS 18.20. The corporation may provide for installment payment of premiums in which event each installment is due by the date specified. The corporation may cancel any of its policies in the event of nonpayment of any premium or installment on a premium, or other charge, by mailing or delivering to the insured at the address shown on the policy and to the agency of the state issuing the insured's license written notice stating when, not less than 10 days after notice is received by the insured, the cancellation is effective.

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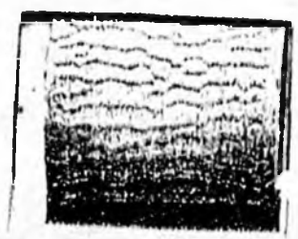
Sec. 21.88.080. REQUIRED INSURANCE; CANCELLATION. The corporation shall provide insurance to all health care providers otherwise eligible for licensure under AS 08.64 and AS 18.20. The corporation may provide for installment payment of premiums in which event each installment is due by the date specified. The corporation may cancel any of its policies in the event of nonpayment of any premium or installment on a premium or other charge by mailing or delivering to the insured at the address shown on the policy and to the agency of the state issuing the insured's license written notice stating when, not less than 10 days after notice is received by the insured, the cancellation is effective.

ARTICLE 3. LOAN FUND.

Sec. 21.88.110. FUND ESTABLISHED. (a) There is in the Department of Commerce and Economic Development a medical malpractice liability revolving loan fund to be administered by the director of insurance.

(b) Loans shall be made from the fund to the corporation upon certification by the director that a loan is necessary for the corporation to maintain adequate reserves or for initial costs of operation. If a loan is made to the corporation from the fund, the corporation shall issue a note to the fund pledging the premiums collected in the future as security for the loan.

(c) Loans from the fund shall be repaid by the corporation within





(b) Every insurer described in (a) of this section shall be a member of the association and shall remain a member as a condition of its authority to continue to transact that kind of business in this state; except that any disability insurer may elect to pay any tax or assessments due without otherwise participating as a member.

(c) The association shall commence operation upon a finding by the director, after public hearing, that after the exercise of due diligence no reinsurance could be procured at reasonable rates by the corporation from a casualty insurer or reinsurer. After the association has commenced operation, if the director determines, after public hearing, that health care malpractice insurance is available through insurers licensed in this state with respect to which he has previously made the former finding, the association shall cease its underwriting operations. At any time, after notice and hearing, the director may, upon a finding that it is no longer needed, terminate the operation of the association.

Sec. 21.88.120. PURPOSE. The purpose of the association is to provide a market for medical malpractice insurance to the corporation on a self-supporting basis without subsidy from association members.

Sec. 21.88.130. ASSOCIATION BOARD OF DIRECTORS; TERM. The association shall be governed by a board of directors appointed by the governor of the state and consisting of two representatives of domestic casualty and property insurers, one representative of admitted disability insurers, one representative of health care service corporations, one representative of foreign casualty and property insurers, and two persons from the public. Members of the board of directors serve three-year terms.

Sec. 21.88.140. ASSOCIATION PLAN OF OPERATION. (a) Within 30 days after the association's creation the board of directors shall

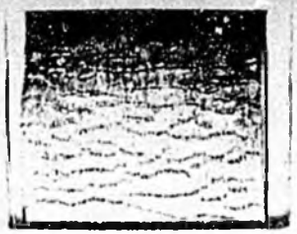
prepare and submit to the director for his approval a plan of operation which provides for the fair, reasonable and equitable administration of the affairs of the association and the discharge of the purposes for which it is created. The plan and any amendments of it become effective upon the director's approval. If the board of directors has failed to submit a plan of operation, or if at any subsequent time the board of directors fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate a plan of operation or amendments which are necessary or advisable to effectuate the provisions of this chapter. Adoption of the plan is not subject to the Administrative Procedure Act (AS 44.62).

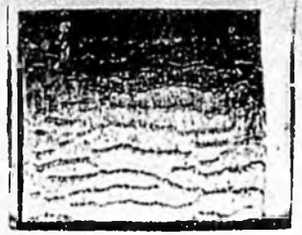
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four years at an annual interest rate of seven per cent.

(d) The director may sell at par value to the Department of Revenue the notes, security instruments and pledge agreements held by the Department of Commerce and Economic Development as security for loans made under this section. The Department of Revenue shall purchase all the notes offered until the current principal amount of the notes purchased and held by the Department of Revenue equals $5,000,000.

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(b) Every insurer described in (a) of this section shall be a member of the association and shall remain a member as a condition of its authority to continue to transact that kind of business in this state; except that any disability insurer may elect to pay any tax or assessments due without otherwise participating as a member.

(c) The association shall commence operation upon a finding by the director, after public hearing, that after the exercise of due diligence no reinsurance could be procured at reasonable rates by the corporation from a casualty insurer or reinsurer. After the association has commenced operation, if the director determines, after public hearing, that health care malpractice insurance is available through insurers licensed in this state with respect to which he has previously made the former finding, the association shall cease its underwriting operations. At any time, after notice and hearing, the director may, upon a finding that it is no longer needed, terminate the operation of the association.

Sec. 21.88.120. PURPOSE. The purpose of the association is to provide a market for medical malpractice insurance to the corporation on a self-supporting basis without subsidy from association members.

Sec. 21.88.130. ASSOCIATION BOARD OF DIRECTORS; TERM. The association shall be governed by a board of directors appointed by the governor of the state and consisting of two representatives of domestic casualty and property insurers, one representative of admitted disability insurers, one representative of health care service corporations, one representative of foreign casualty and property insurers, and two persons from the public. Members of the board of directors serve three-year terms.

(b) the plan of operation shall

(1) establish the procedures for carrying out the powers and duties of the association specified in sec. 150 of this chapter;

(2) establish procedures for handling assets and discharging liabilities of the association;

(3) establish regular places and times for meetings of the board of directors;

(4) establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(5) establish the amount and method of reimbursing members of the board of directors;

(6) establish the procedures for awarding contracts to indemnify or defend or to provide other services and to compensate the indemnitors or vendors;

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(7) establish the procedures for issuing contracts of insurance as provided in sec. 150 of this chapter and for the determination of rates;

(8) contain additional provisions necessary or proper for the execution of the powers and duties of the association.

Sec. 21.88.150. POWERS AND DUTIES OF THE ASSOCIATION. (a) The association shall

(1) provide reinsurance to the corporation covering contracts issued by the corporation indemnifying health care providers and their employees who are health care providers against loss by reason of liability for professional services and agreeing to tender on behalf of the health care providers and their employees who are health care providers a defense in an action brought under AS 09.55.530 - 09.55.560; the limit of liability shall be no less than the minimum liability required to be indemnified as provided in AS 08.64.215 and AS 18.20.045, and the coverage shall be the same as that which the Health Care Providers Indemnity Corporation is required to provide under sec. 50 of this chapter;

(2) charge a premium for the protection provided by the contracts issued under sec. 50 of this chapter which shall be determined by the board of directors in accordance with sec. 80 of this chapter and subject to the approval of the director;

(3) comply with or be subject to AS 21.06.090; 21.06.120; 21.06.140; 21.06.160; 21.06.250; AS 21.09.180; 21.09.200; 21.09.250; 21.09.280; AS 21.12.020(b), (c), (d), and (e); and chs. 18, 21, 24, and 36 of this title;

(4) carry out the obligations of the contracts issued under sec. 50 of this chapter by defending all covered claims made against insured health care providers and paying all liabilities which are

finally adjudicated against the insured health care provider or which p35 may in the opinion of the association reasonably be expected to be finally adjudicated against the health care provider to the extent of the contract obligation.

(b) The association may

(1) employ or retain persons, individual or corporate, to discharge its obligations and pay reasonable compensation for those services;

(2) provide reinsurance to the corporation for coverage to health care providers for other hazards where there is a finding by the director that this coverage is otherwise unavailable by reason of the operation of the corporation;

(3) provide reinsurance to the corporation for coverage to health care providers for liability under AS 09.55.530 - 09.55.560 in excess of the minimum limits required for licensure as a health care provider where there is a finding by the director that this coverage is unavailable at a reasonable cost and that this coverage can be made available at a reasonable cost through the corporation;

(4) provide reinsurance to the corporation for coverage for liability under AS 09.55.530 - 09.55.560 to chiropractors licensed under AS 08.20, dental hygienists licensed under AS 08.32, dentists licensed under AS 08.36, nurses licensed under AS 08.68, dispensing opticians licensed under AS 08.71, optometrists licensed under AS 08.72, pharmacists licensed under AS 08.80, physical therapists licensed under AS 08.84, and psychologists and psychological associates licensed under AS 08.86;

(5) borrow or advance funds necessary to effectuate the purposes of this association;

(6) negotiate and become a party to those contracts which are necessary to carry out the purposes of the association;

(7) sue or be sued in the name of the association;

(8) cede or assume reinsurance;

(9) perform all other acts necessary and proper to effectuate the association.

Sec. 21.88.160. RATES AND RATING PLANS. The rates and rating plans shall be determined as provided in sec. 80 of this chapter, except that allowance may not be made for profit to an indemnifying carrier or for income from investment of member-contributed funds; and provided that reserves for claims incurred during the policy period and reasonably expected to be reported after three years after the incident may be included on a different basis due to the additional financial flexibility provided by the association.

able for the sound financial operation of the association, all members shall contribute to the financial requirements of the association by paying to the association an assessment to be determined by the board of governors of the association, these assessments to be prorated among all members in proportion to their direct written premiums or revenues in this state in the insurance lines the writing of which require membership in the association, in the two years ending on the preceding December 31, after deducting the applicable cancellations, returned premium, the unabsorbed portion of any deposit premium, all policy dividends, unabsorbed premiums refunded to policyholders, refunds, savings, savings coupons and other similar returns paid or credited to policyholders with respect to their policies. Any assessment under this section is a tax obligation in addition to taxes required under AS 21.09.210 and notwithstanding the provisions of AS 21.09.210(e).

Sec. 21.88.180. RATE ADJUSTMENT. (a) If in any year an assessment is made under sec. 170 of this chapter, rates for the next period shall be increased from the rate determined under sec. 160 of this chapter by an amount sufficient to reimburse all members the amounts assessed.

(b) No assessment may be reimbursed to members without prior approval of the director and no interest accrues in favor of members on amounts assessed.

(c) If, after establishing required reserves, there is an excess amount in reserve, the excess premium shall be refunded to the insured health care providers.

Sec. 21.88.190. REPORTS. At least annually the association shall report to the director concerning its affairs. The report shall be in the form prescribed by the director.

ARTICLE 4. LOAN FUND.

Sec. 21.88.210. FUND ESTABLISHED. (a) There is in the Department of Commerce and Economic Development a medical malpractice liability revolving loan fund to be administered by the director of insurance.

(b) Loans shall be made from the fund to the Joint Underwriting Association upon certification by the director that a loan is necessary for the corporation to spread costs out over time because of fluctuations in loss experience. If a loan is made to the corporation from the fund, the Joint Underwriting Association shall issue a note to the fund pledging the premiums collected in the future as security for the loan.

(c) Loans from the fund shall be repaid by the Joint Underwriting Association within five years at an annual interest rate of six per cent.

Original Sponsor: Rules Committee by request of the Governor

Offered: 3/2/76
Referred: Rules

IN THE HOUSE BY THE COMMERCE COMMITTEE

SENATE CS FOR CS FOR HOUSE BILL NO. 574 am S

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to health care changing the Alaska Supreme Court's Rules of Civil Procedure; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 08.01.050 is amended by adding a new paragraph to read:

(19) provide investigative services to the boards established under chs. 20, 32, 36, 64, 68, 71, 72, 80, 84, and 86 of this title, for the purpose of assisting those boards in matters of professional discipline.

* Sec. 2. AS 08.20.010 is amended to read:

Sec. 08.20.010. CREATION AND MEMBERSHIP OF BOARD OF CHIROPRACTIC EXAMINERS. There is created the Board of Chiropractic Examiners consisting of five [THREE] members appointed by the governor.

* Sec. 3. AS 08.20.020 is amended to read:

Sec. 08.20.020. MEMBERS OF BOARD. Three members [EACH MEMBER] of the board shall be [A] licensed chiropractic physicians who [PHYSICIAN AND SHALL] have practiced chiropractic in this state not less than two years. Two members of the board shall be persons with no direct financial interest in the health care industry. Each member serves without pay but is entitled to per diem and travel expenses allowed by law.

* Sec. 4. AS 08.20.030 is repealed and re-enacted to read:

Sec. 08.20.030. MEMBERS TERMS, VACANCIES. Members serve for staggered terms of three years. The terms of the public members of the board may not expire at the same time. Vacancies on the board shall be

filled for the unexpired term.

Original sponsor: Rules Committee by request of the Governor

Offered: 2/24/76

Keith

IN THE HOUSE BY THE JUDICIARY COMMITTEE

CS FOR HOUSE BILL NO. 574

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to liability for the provision of health care services; changing the Alaska Supreme Court's Rules of Civil Procedure; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 08.01.050 is amended by adding a new paragraph to read:

(19) provide investigative services to the boards established under chs. 20, 32, 36, 64, 68, 71, 72, 80, 84, and 86 of this title, for the purpose of assisting those boards in matters of professional discipline.

(d) The director may sell at par value to the Department of Revenue the notes, security instruments and pledge agreements held by the Department of Commerce and Economic Development as security for loans made under this section. The Department of Revenue shall purchase all the notes offered until the current principal amount of the notes purchased and held by the Department of Revenue equals $5,000,000.

ARTICLE 5. GENERAL PROVISIONS.

Sec. 21.88.900. DEFINITIONS. As used in this chapter,

(1) "association" means the Health Care Providers Joint Underwriting Association;

(2) "corporation" means the Health Care Providers Indemnity Corporation;

(3) "health care provider" means a physician licensed under AS 08.64 and a hospital licensed under AS 18.20.

* Sec. 40. AS 21.18.090 is amended by adding a new paragraph to read:

(5) reserves for the Joint Underwriting Association are to include claims reported and unpaid; reserves for claims incurred but not reported, but those which may reasonably be expected to be reported beyond three years after the date of occurrence may be included on a different basis due to the additional financial flexibility of the association.

* Sec. 41. AS 08.02 is amended by adding a new section to read:

Sec. 08.02.020. LIMITATION OF LIABILITY FOR MEMBERS OF LICENSING BOARDS. No person is liable for damages or other relief in an action by reason of his performance of a duty, function, or activity as a member of a licensing board or by reason of a recommendation or action of the board when the person acts in the reasonable belief that his action or recommendation is warranted by facts known to him or to the board after reasonable efforts to ascertain the facts upon which the

ARTICLE 4. GENERAL PROVISIONS.

Sec. 21.88.300. DEFINITIONS. As used in this chapter,

(1) "corporation" means the Health Care Providers Indemnity Corporation;

(2) "director" means the director of the division of insurance for the State of Alaska;

(3) "fund" means the medical malpractice liability revolving loan fund;

(4) "health care provider" means a physician licensed under AS 08.64 and a hospital as defined in AS 18.20.130, including a hospital or health care facility owned or operated by the state or one or more of its political subdivisions; if at any time the director of insurance mandates chiropractors under AS 08.20.115(b), dental hygienists under AS 08.32.015(b), dentists under AS 08.36.115(b), nurses under AS 08.68.165(b), dispensing opticians under AS 08.71.085(b), optometrists under AS 08.72.115(b), pharmacists under AS 08.80.115(b), physical therapists under AS 08.84.035(b), or psychologists and psychological associates under AS 08.86.125(b) into participation in the corporation, they shall then be considered health care providers for the purposes of this chapter;

(5) "occurrence basis insurance" is insurance against claims arising during the period of the policy coverage.

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* Sec. 24. AS 21.18.090 is amended by adding a new paragraph to read:

(5) reserves for the Health Care Providers Indemnity Corporation are to include only reserves for claims reported and unpaid and reserves for claims incurred but not reported but which may reasonably be expected to be reported within three years after the date of occurrence.

* Sec. 42. AS 09.55.535, and AS 09.55.537, enacted in sec. 31 of this Act, have the effect of changing the Alaska Supreme Court's Rules of Civil Procedure by requiring the submission of medical malpractice claims against hospitals and physicians to either nonbinding arbitration or to expert advisory panels, unless all parties to the action agree otherwise.

* Sec. 43. AS 08.64.365 and AS 08.68.040 are repealed.

* Sec. 44. This Act takes effect 30 days after enactment.

* Sec. 25. AS 09.55.536 enacted in sec. 15 of this Act, has the effect of changing the Alaska Supreme Court's Rules of Civil Procedure, by requiring the submission of each health care malpractice action to a panel of experts.

* Sec. 26. AS 08.64.365 is repealed.

* Sec. 27. This Act takes effect 30 days after enactment.

Allow anytime before filing a suit whether previously agreed or not (1)

Sec. 4 AS 09.55.530 is repealed and recreated to read:

ARTICLE 6. MALPRACTICE ACTIONS.

Sec. 09.55.530. DECLARATION OF PURPOSE. The legislature finds that the health of the people is threatened by curtailment of health care services due to the difficulty in obtaining adequate malpractice insurance at a reasonable cost. It is the purpose of secs. 530 - 560 of this chapter to protect the health and safety of the people of this state by establishing procedural aids for handling malpractice claims which will help ensure the ready availability of adequate insurance at a reasonable cost and which will be fair to all parties concerned.

Sec. 09.55.532 VOLUNTARY ARBITRATION. (a) A patient and any health care provider may execute an agreement to submit to arbitration any dispute, controversy, or issue arising out of care of treatment by the health care provider during the period that the agreement is in force or that has already arisen between the parties.

(b) An agreement to arbitrate executed before care or treatment is provided between a patient and health care provider shall clearly provide in bold print on the face of the agreement that execution of the agreement by the patient is not a prerequisite to receiving care or treatment. If this subsection is not complied with by the health care provider, the agreement to arbitrate is void. The form to be used shall be approved in advance by the (Attorney General) director of insurance to assure it fairly informs the patient and properly protects his interests.

(c) Each admission to a hospital shall be treated as separate and distinct for the purposes of an agreement to arbitrate, but a person receiving outpatient care from a hospital or clinic or a member of a health maintenance organization may execute an agreement with the hospital which provides for continuation of the agreement for a continuing program of treatment or during continued membership.

(d) The arbitration board shall consist of three arbitrators: one arbitrator designated by the plaintiff or plaintiffs, one arbitrator designated by the defendant or defendants, and a third arbitrator designated by mutual agreement who shall serve as chairman of the board. If the parties cannot agree on the third person, the court will provide a list of three or more persons who might serve as chairman of the arbitration board, which shall be furnished by the attorney general. Plaintiff or plaintiffs together and defendant and defendants together may each strike one or more names from the list, so after each side has done so, at least one name remains on the list, providing a basis for the final selection by the court.

(e) The attorney general shall prepare a list of panelists consisting of lawyers or other persons qualified to serve as chairmen of arbitration boards. They shall be selected on basis of their technical expertise, judicial temperament, and capability of impartially acting on malpractice claims. The attorney general shall submit a list of at least three names of panelists whenever requested to do so by the court along with detailed biographical information on each panelist.

(f) Each member of the board shall receive reasonable compensation to be paid by the court based on the extent and duration of services rendered. The court shall also pay the costs of experts required by the board, to a maximum of $150/day for each of 3 experts for each party.

(g) The court shall specify the shortest practical deadline for completion of the work of the arbitration panel, taking into account all the circumstance and the nature of the case.

(h) The provisions of the Uniform Arbitration Act, AS 09.43.010 - 09.43.180, apply to arbitrations under this section insofar as they are applicable and do not conflict with the provisions of this section; arbitrations under this section shall be conducted in accordance with any rules of court which may be adopted.

(i) It shall be a condition of the arbitration agreement that the results are binding on both parties

* Sec. 15. AS 09.55 is amended by adding a new section to read:

Sec. 09.55.535. EXPERT ADVISORY PANEL. (a) In any action for damages due to personal injury or death based upon the provision of professional services by a health care provider, the court shall establish a three-person expert advisory panel in accordance with this section. When the action is filed the court shall, by order, determine the professions or specialties to be represented on the expert advisory panel and shall advise each party of the professions or specialties to be represented, giving the parties the opportunity to object or make suggestions. The court may in its discretion conduct other preliminary proceedings relative to the composition of the panel as it considers appropriate.

(b) The expert advisory panel may compel the attendance of witnesses, interview the parties and physically examine the injured person if alive, consult with the specialists or learned works they consider appropriate, and compel the production of and examine all relevant hospital, medical, or other records or materials relating to the health care treatment. The panel may meet in camera, but shall maintain a record of any testimony or oral statements of witnesses, and shall keep copies of all written statements and opinions it receives. Not more than 30 days after selection of the panel, it shall make a written report to the parties and to the court, substantially answering the following questions in addition to any other question which the court puts to the panel:

(1) What was the medical complaint or condition for which the person sought or was brought to medical care?

(2) What would have been the likely course of the complaint or condition without the medical care?

(3) Was the care appropriate?

(4) Did an injury arise from the medical care?

(5) What was the injury?

(6) Is the injury stable; or will it improve or become worse?

(7) What specifically caused the injury?

(8) Was the injury caused by negligence?

(9) Is the outcome different than would otherwise have been expected?

(c) In any case in which the answer to one or more of the questions under (b) of this section depends upon the resolution of factual questions which are not the proper subject of expert opinion, the report shall so state and may answer questions based upon hypothetical facts that are fully and completely set out in the opinion. The report shall include copies of all written statements, opinions, or records relied upon by the panel and either a transcription or other record of any oral statements or opinions; shall specify any medical or scientific authority relied upon by the panel; and shall include the results of any physical or mental examination performed on the plaintiff. Each member shall sign the report and his signature constitutes his adoption of all statements and opinions contained in it; however, a member may, instead of signing the report, submit a concurring or dissenting report which complies with the requirements of this subsection, and a member may not attest to any portion of the report as to which he is not qualified to give expert testimony.

(d) No discovery may be undertaken in a case until the report of the expert advisory panel is received. However, the court may relax this prohibition upon a showing of good cause by any party. If the panel has not completed its report within the 30-day period prescribed in (b) of this section, the court may, upon application, grant it an additional 30 days.

(e) The report of the panel and any dissenting or concurring opinion are admissible in evidence to the same extent as though its contents were orally testified to by the person or persons preparing it. The court shall delete any portion that would not be admissible because of lack of foundation for opinion testimony, or otherwise. Either party may submit expert testimony to support or refute the report. The jury shall be instructed in general terms that the report shall be considered and evaluated in the same manner as any other expert testimony. Any member of the panel may be called by any party and may be cross-examined as to the contents of the report or of his dissenting or concurring opinion.

(f) Members of a panel are entitled to travel expenses and per diem in accordance with state law pertaining to members of boards and commissions for all time spent in preparing its report and matters incidental to it. If a panel member is called upon as a witness at trial or upon deposition, he is entitled to payment of an expert witness fee. All expenses incurred by the panel shall be paid by the ~~state~~ court. However, in any case in which the court determines that a party has made a patently frivolous claim or a patently frivolous denial of liability, it shall order that all costs of the expert advisory panel be borne by the party making that claim or denial.

(g) Parties to the case and their counsel may not initiate communication out of court with members of the panel on the subject matter of its inquiry and report or cause or solicit others to do so, except through ordinary discovery proceedings.

AMENDMENTS TO WORK DRAFT

FCCS SCS CSHB 574

5/11/76

page 32, line 15-16

...a board of governors the first members of which are appointed...

page 33, line 3-4

Upon the expiration of the term of governor, those insured by the corporation shall elect a successor...

Page 33, line 8

...serve, the board of governors shall appoint...

line 11

strike all of subsection (d)

line 16

...the corporation at rates to be established by the board of governors in the plan of operation.

page 35, line 24
through page 36, line 8

Strike all of section (3) and insert in lieu:

(3) Use due diligence to procure reinsurance from private insurers or reinsurers or public medical malpractice reinsurance facilities for any or all of the liability insured by contracts issued by the corporation. If after the exercise of due diligence, reinsurance for claims reported within three years after date of occurrence cannot be procured at reasonable rates from private insurers or reinsurers the corporation, through the board of governors may so certify to the director and subject to the approval of the director, that portion of the risk for claims reported within three years after date of occurrence not reinsured in private insurers or public medical malpractice reinsurance facilities, shall be provided by the health care providers Joint Underwriting Association established under secs. 110-180 of this chapter.

Page 36, line 9

(4) charge a premium and special assessments for the protection...

Page 37, line 12-19

strike all of subsection (2) and insert in lieu:

(2) cede or assume reinsurance for any or all risk which the corporation is authorized to insure directly.

Page 40, line 18

strike subsection (14) and insert in lieu:

(14) rates may include special assessments of insureds to cover newly reported claims for which insufficient reserves have been established.

Page 41, line 18-20

certifies to the director that after due diligence the Board of Directors could not procure reinsurance from private reinsurers or from public medical malpractice reinsurance facilities for claims reported within three years after date of occurrence and if the director finds, after public hearing that a market for reinsurance is needed and providing it through the association is in the public interest.

Page 46, line 8, "upon" to line 22 "used"

Strike

line 23

...respect of policyholders and initial operating costs, and many not...

Page 47, line 6

...notes [security instruments and pledge agreements] held by...

line 10

...equals [$6,000,000] $3,000,000

Licensing + Discipline Provisions

Example

* Sec. 6. AS 08.20 is amended by adding a new section to read:

Sec. 08.20.175. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 170 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education or health the authority to practice chiropractic should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure or facility, require additional education or training, ~~or~~ and revoke or suspend a license.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

Colletta & Rosky

Suggested Amendment for Senate Bill SCSCSHB 574 am S

Page 19 Section 18.20.045 - to replace Subsection (b)

Suggested Amendment for Section 18.20.045 - House Bill CSHB 574 am page 16

Addition to House Bill:Amendment would be added as subsection (a)

The Director of Insurance or his designee shall waive the requirement in (a) of this section for a hospital if the hospital furnishes satisfactory evidence of having other liability insurance providing coverage in amounts equal to or which exceed those specified in (a) of this section, and at a premium rate which does not exceed the premium rate offered by the Health Care Providers Indemnity Corporation for an equal amount of liability coverage. A waiver granted under this subsection may extend beyond the normal expiration date of the hospital's insurance policy or until such time as the policy's premium rate exceeds that which would be offered by the Health Care Providers Indemnity Corporation for an equal amount of coverage.

This should be added to BS. 18, 20.005 —

750
400

(c) The Director of Insurance may waive the requirement in (a) of this section or permit a deductible provision in the policy for a hospital, if the hospital:

i) can demonstrate to the satisfaction of the Director of Insurance that without indemnity from any other source, the hospital has the financial resources to discharge the maximum potential exposure to the hospital by reason of the deductible provision.

ii) agree to permit the Health Care Providers Indemnity Corporation to provide defense of any claim brought against the hospital if any health care provider insured by the corporation is also involved in the claim and to reimburse the corporation for a prorata portion of the costs of defense.

iii) provides the Health Care Providers Indemnity Corporation with notice of any claim brought against it.

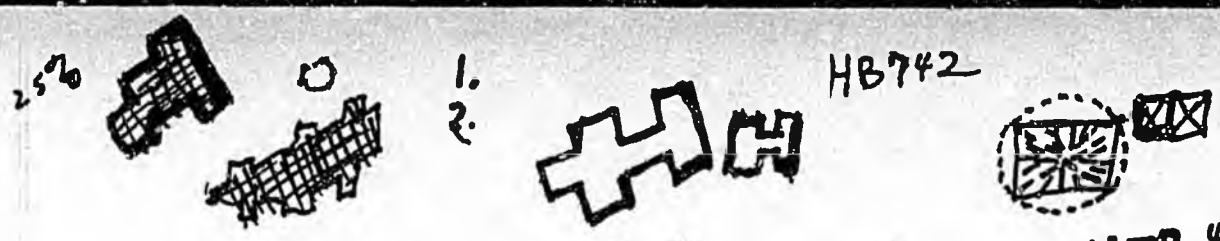
Mr. Richard Block

Terry Gardiner

Is this

true ?

Nils



Medical Malpractice

1. Sent of Committee Work & Commission
   Time to Move out even though not perfect
   14 Sessions Meeting 27 com hearings
   5 drafts

Commission legislation was base of Comm. Work

HB 575 & HJR 48 – opposition in Com. Agreed tentatively to work on concept of Residency Req – out next week.

Key Changes.

1. A. Mandatory Physicians & Hosp.
   B. Insurance coverage Mandatory other professions
   C. Mechanisms to cover others in crisis
   D. Continuing Educations for Physicians to improve quality of Med Care & reduce Med Mal.
   E. Risk Management Program for Hospitals

Expert Advisory – Expert + Unbiased opinion to parties of a suit; then court & jury on Medical Questions only

discretion.

Do effort cut insurance costs - Periodic payments / lump sum
Deduction of Collateral payments in injury

1. A. Informed consent to protect both patient & Physician
   B. Good Samaritan statute cleanup
2. C. Immunity for review Organizations in Hospitals encourage improvement of Medical services in Hosp.

Health Care Providers Indemnity Corporation

Amended to include 2 consumers & 1 member of Medical clinic to Rep their interests

Retained Retroactive coverage to Dec 31, 1974 ⅓ physicians have no insurance

Provide for Management services by Insurance 6 for example to run the MIC "Not adding another state ~~Rep~~ agency"

Rates will be based on Medical Revenue adding on other factors of Risk & Practice such as: ① Member of a clinic ② History of Mal Practice Claims ③ Amount of time practicing

State loan at 7¾% ↗ repaid over 4 years to reinsure fund if needed. Estimate initial loan of 250,000 for start up - Claims will not come in for several years actually $5 Million loan limit - Could raise in future if necessary

1. 2 Consumers on Boards
2. Continuing Ed for All prof.
3. Advance Payment
4. Ad Damnum
5. fix Collateral exhaustion
6. Change Gov appointment no panels

JUA Authority for All Insurance problems

Wisconsin did in 1967 - utilized when malpractice crisis came up

Dept of Commerce Report to Legis Jan 1

1. Activities + any changes of Prof licensing Bds and com 57
2. Any problems of Ins coverage + rates of hospitals and other health care providers outside physicians
3. implementation of continuing education 8.64.312
4. Use of voluntary arbitration 9.55.535
5. " of Expert advisory panel 9.55.536
6. Hospital exemption 18.20.045
7. implementation of risk management for hospitals 18.20.0
8. MIC
   A. rates of insurance by classification of physician
   B. extent of physician coverage
   C. Financial condition of MIC losses reserves etc.
      A. Breakdown of premium dollar
      B. excess coverage of other ins provided
   D. Comparison of Alaska to other state ins rates
   E. Disposition of any claims against MIC
   F. Any loan received from state + payback

- profit on the overall - not specific -

1. controllable portion
2. Reserves in bill.

3	3
- Primary coverage -	Reinsurance
A & T 3	A & T 3
AAA Primary coverage	Reinsurance

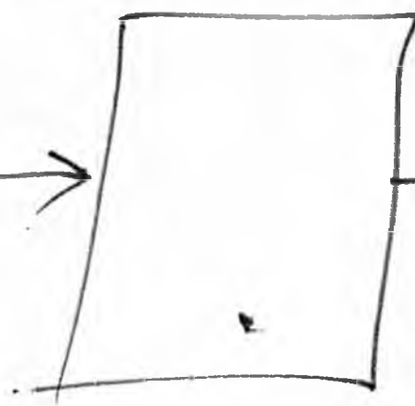
(00) Insured

Primary

Lloyds



5,000



1,000,000

FACULTATIVE

500 (INSUREDS



COLORADO



FACULTATIVE (individual)

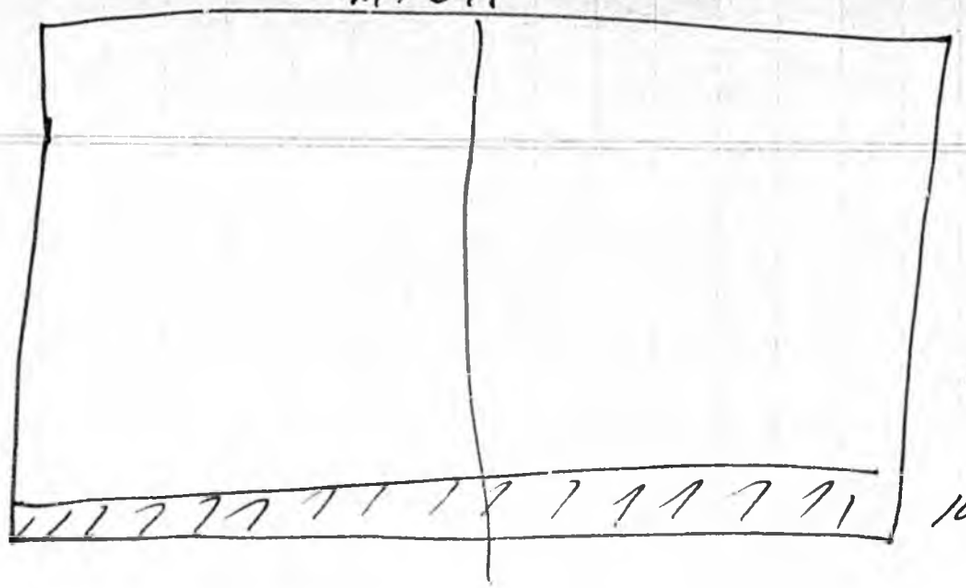
TREATY (whole book or class of business)

QUOTA SHARE 50%

EXCESS. per occurrence

STOP LOSS AGGREGATE — total loss on entire book in addition to treaty recoveries

MICA

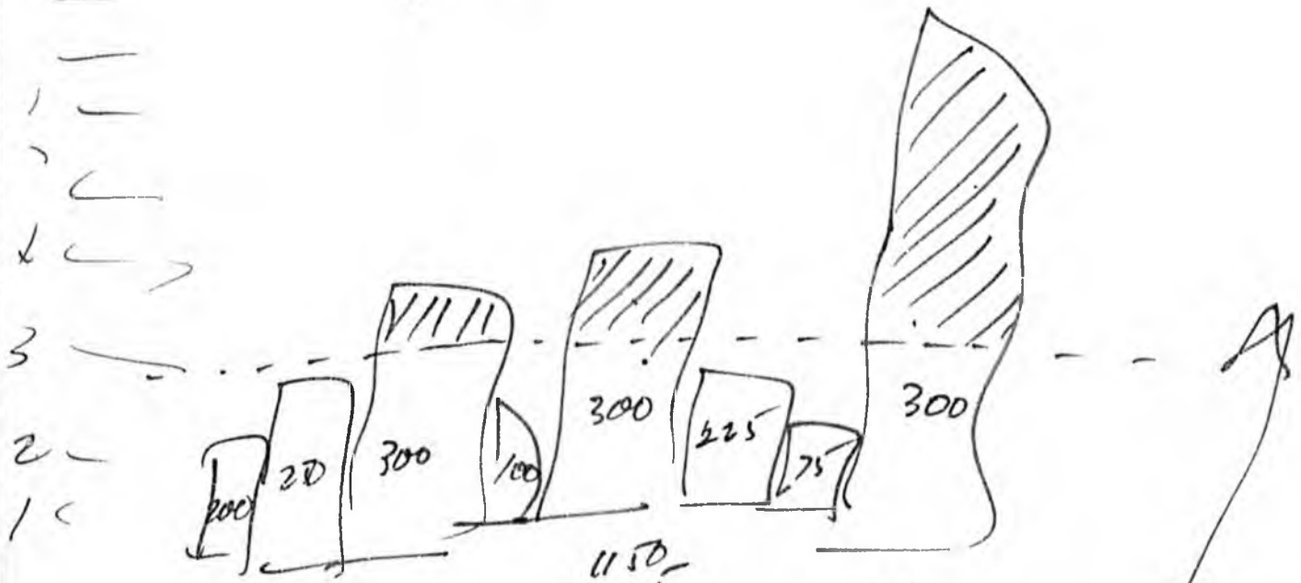


100% - Q.S. 1,000,000

100% Q.S. 100/300

1,000,000

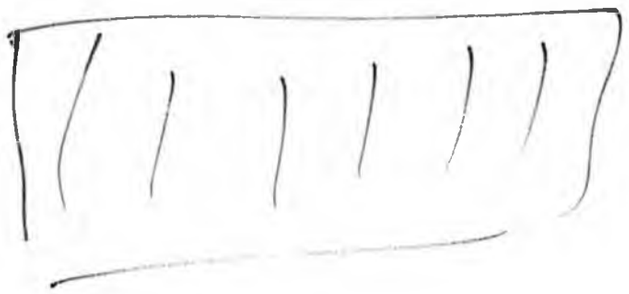


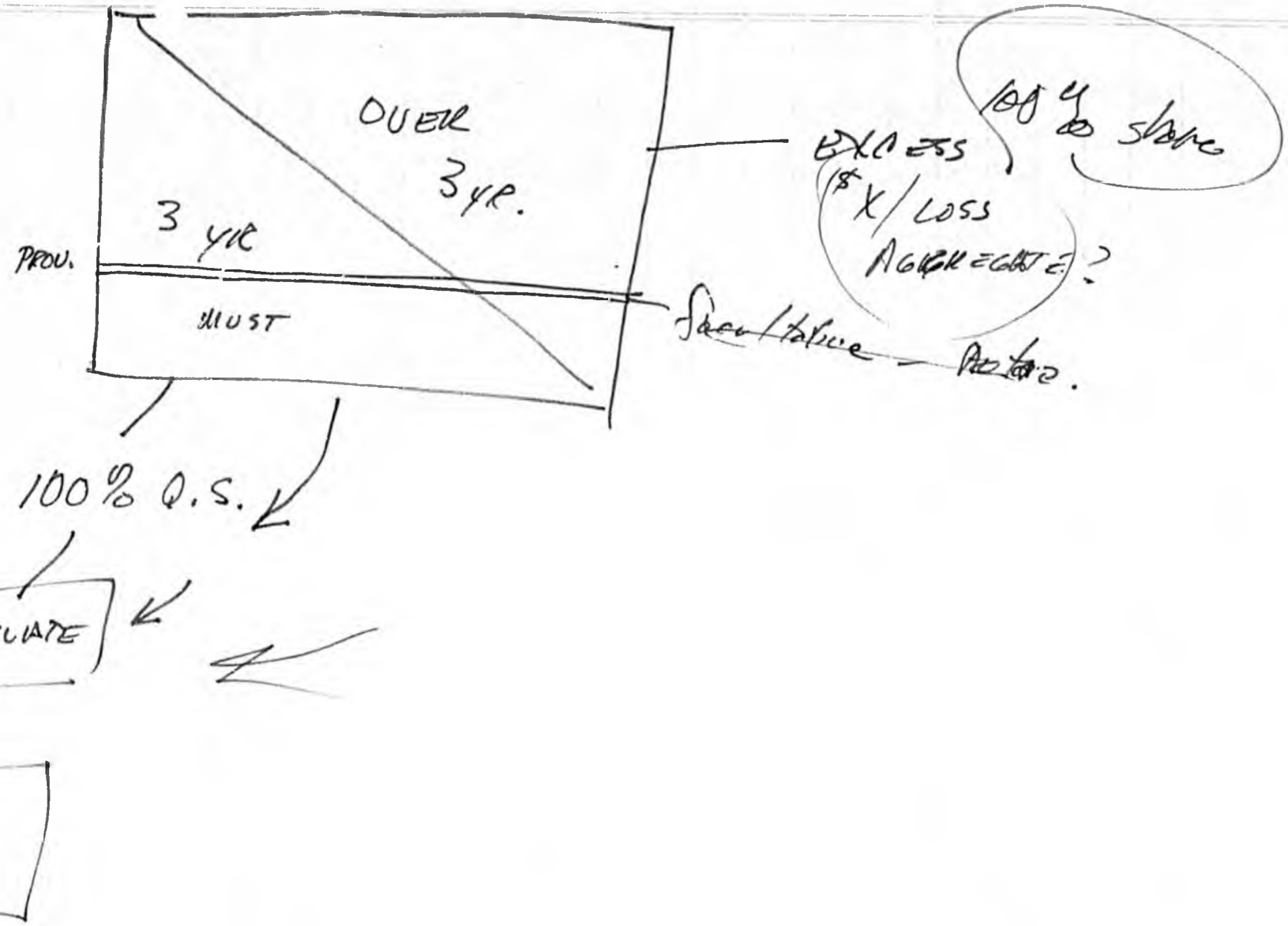


1150
225
1375
375
1750

$1,750,000

$11,000,000




OVER
3 yr.
3 yr
PROV.
MUST
EXCESS
$ X / LOSS
AGGREGATE ?
100% Q.S.
PRIVATE
1 U.A.

Alaska State Medical Association 3-8-76

574

CONCEPTS INCLUDED

	HB	SB
1. Investigative powers to licensing boards p.1; p.1	X	X
2. Adding two lay persons to boards Adopt Senate p.1-9		X
3. Broader powers for boards p.1-9; p.2-10	X	X
4. Immunity for boards p.39		X
5. Continuing education for physicians p.4	X	
6. Mandatory insurance for all providers p.1-9,16	X	
7. Mandatory insurance only for physicians & hospitals p.4,19		X
8. Waiver for insured physicians until 1-1-77 p.4; p.4	X	X
9. Waiver for insured hospitals until 1-1-77 p.19		X
10. Expert Advisory panel	X	X
a. Three person p.10	X	
b. Always used; discovery stayed p.10,12	X	
c. At option of arbitration board or court p.11,13		X
d. Specific questions to answer p.11	X	
e. Opinion admissible on appeal p.12; p.14	X	X
11. Mandatory nonbinding arbitration p.10		X
12. Voluntary binding arbitration p.12		X
13. Burden of proof p.13; p.15	X	X
14. Advance payment not prejudicial p.16		X

		HB	SB
15.	Ad damnum prohibited p.16		X
16.	Awards itemized by category of loss p.13; p.16	X	X
17.	Periodic payment allowed p.13; p.16	X	X
18.	Periodic payments increased by consumer price index p.14	X	
19.	Collateral source substracted from award p.14; p.16	X	X
20.	Collateral coverage protected from exhaustion p.17		X
21.	Jury instructions as to proof p.14; p.17	X	X
22.	Oral contracts invalid p.14	X	
23.	Informed consent p.14; p.17	X	X
24.	Emergency aid p.16; p.18	X	X
25.	Risk management in hospitals p.16	X	
26.	Immunity for review organizations p.17; p.19	X	X
27.	Indemnity Corporation created by state p.22; p.24	X	X
28.	Occurrence malpractice insurance p.25; p.27	X	X
29.	Retroactive insurance for 1975 gaps p.25; p.27	X	X
30.	Provision for excess coverage p.26; p.29	X	X
31.	Rates for physicians tied to medical revenues p.28	X	
32.	Rates for hospitals tied to number of beds p. 28	X	

		HB	SB
33.	Rates related to 3 year reserving for losses p. 28; p.31	X	X
34.	Premium tax p.30		X
35.	Installment payment of premiums p.29; p.32	X	X
36.	Reinsurance of basic insurance in private market p.38		X
37.	Reinsurance of excess insurance in private market p.26; p.28	X	X
38.	Statistic gathering and reporting p.27; p.30	X	X
39.	Revolving loan fund for Indemnity Corporation (7%) p.29	X	
	for JUA (6%) p.38		X
40.	JUA p.32		X

THE ALASKA CLINIC

A PROFESSIONAL CORPORATION

825 L STREET

ANCHORAGE, ALASKA 99501

907-279-0622

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MAX KERSBERGEN, ADMINISTRATOR
JAMES HOONCE, BUSINESS MANAGER

We, at The Alaska Clinic in Anchorage, believe that the clinics in Alaska should be considered separately from the other physicians in the matter of the malpractice insurance problem. There are a lot of different reasons why we believe this and the first of these reasons is that these groups currently do have their malpractice insurance in effect and will probably continue to be able to do so.

Other reasons probably require considerable discussion and will be as follows: We next believe that the better medical care can be and is provided by the groups in practice and the insurance companies recognize this and are better able to monitor the performances of these groups to ensure that they are better risks for malpractice coverage.

Other reasons will probably be much more related to the particular differences presented by The Alaska Clinic in Anchorage as you will see. The biggest problem of all will be the particular hardships of this mandatory exclusive and/or premium based on gross income. To begin with, The Alaska Clinic has been in practice and has had a good record since 1947. Over the years, this Clinic has attempted to meet the requirements of the community to the best of its ability and it has, particularly during the past 15 years, made considerable progress in providing extensive services to the public in this area. The Clinic, together with the rapidly growing and expanding offspring, Anchorage Community Hospital, represents a major segment of health care in the Anchorage area. Together these two organizations provide employment for over 500 individuals currently, and with the expansion program already well under development in a year or so, should anticipate almost doubling this number of employees. Certainly by this time, it should represent one of the larger private businesses and industries in the Alaska area, certainly one of the very largest that is locally directed and administered and controlled.

We believe that it is an over-simplification to try to equate the situation of the solo-practitioner, with no employees and little overhead with a member of The Alaska Clinic who shares in the economic and professional responsibilities of a multi-million dollar medical center with hundreds of employees.

It works out that the overhead per month for The Alaska Clinic member is approximately $20,000 before his own salary begins. This annually amounts to the neighborhood of $240,000 excluding his own salary. If one were using a percentage of gross income to determine the amount of insurance costs in this instance for a member of The Alaska Clinic paying 5% of gross revenue, his bill would be over $12,000 before any money is paid for his premiums for his own personal insurance. The Clinic already has its own problems to deal with that are of great concern to us. One of the biggest problems is keeping its staff of physicians and continuing to develop to meet the responsibilities it has coming. We cannot pay high enough salaries to our members to compete with the solo practitioners across town. We already have lost numbers of our members that are now practicing competitively with us in town because they are able to earn considerably more money in that capacity than they were able to earn as Clinic members. As a matter of fact, in order to obtain some types of special services in the Clinic, we are currently having to pay as much as 50% more salary per member in some categories than for the regular full-time older members of the Clinic themselves. The good record of the Clinic with its relatively lower costs of insurance in the past and presently is one of the few inducements to maintain our staff membership.

We believe that the insurance companies have provided great service in the past to the public by preventing malpractice to a great extent. Companies have recognized differences in the risk of various services as well as risks between various physicians. They have regulated and prevented a great amount of malpractice by insisting on premiums high enough to prevent work that is not up to par or procedures done in some areas where there are unnecessary risks. It really sounds like the plan now is to deny this very important regulating mechanism and perhaps even to require that many physicians support procedures that they are very much opposed to. We believe that the insurance companies have been able to do a better job in this important service to the public that the physicians have been able to do for themselves. The members of The Alaska Clinic view the proposed legislation as highly detrimental to the Clinic and a serious obstacle for its entire future development. We can even see it leading to the ultimate failure of the entire project. It is absolutely necessary for the Clinic to expand to meet the demands of its increasing responsibilities We believe that the Clinic has assumed a major responsibility in development of medical facilities that will be important to the entire State. A change of the present malpractice coverage makes it impossible for us to proceed.

We can speak only for our own group and we do not have any data on what the impact will be for the other clinics involved. We can say with assurance, however, that it will be a disaster to the future development of the new medical center under construction, if The Alaska Clinic is drawn into any mandatory or exclusive insurance program on a Statewide basis. We also object to a program of this type based on gross revenues as being unreasonable and unfair.

We advise that the Clinic be permitted to maintain their own malpractice insurance program with its built-in standards review and risk control. It is a nationwide program with over a hundred clinics participating. We believe it is in the the best interest of the people of the State to encourage group practice wherever possible.

_____,M.D.
Vernon A. Cates, M.D.

VAC/ds

Malpractice file

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J. B. BRADLEY
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L. B. JACOBSON
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PLEASE REPLY TO
☒ JUNEAU OFFICE
☐ ANCHORAGE OFFICE

A PROFESSIONAL CORPORATION

March 8, 1976

The Honorable Terry L. Gardiner
Alaska State House
of Representatives
Pouch V
State Capitol Building
Juneau, Alaska 99811

Dear Terry:

On behalf of the American Life Insurance Association, I have tried, to no avail, to convince the members of the Senate Commerce Committee of the seriousness of the problems which will result if life insurance companies which write disability insurance are included in a JUA. I have enclosed two letters that I wrote to Senator Kerttula and the members of the Commerce Committee. I am also enclosing the policy statement of one of the associations of life underwriters and agents within the State. They are concerned, as they have every right to be, that their companies will simply be unable to write disability insurance within the State. I hope that the JUA is not found to be necessary by the Free Conference Committee on the Malpractice Bills, but if it is, I certainly hope that it will not include life insurance companies who write disability insurance.

I will be out of town until Tuesday evening, but I have asked the life agents to contact you concerning this problem.

Sincerely,

M. T. THOMAS

MTT:kh
Enclosures



FAIRBANKS MEDICAL & SURGICAL CLINIC, INC.

FOUNDED IN 1932

522 FIFTH AVENUE P.O. BOX 1330 FAIRBANKS, ALASKA 99707 907-452-1761

Representative Terry Gardiner March 10, 1976
Pouch V
Juneau, Alaska 99801 Re: Medical Malpractice

Dear Mr. Gardiner;

Just a note to express my recommendations about medical malpractice insurance.

I object to mandatory membership if it means losing the group insurance I now possess.

I object to an arbitration board — I prefer an adjudication board.

I hope the premiums will be based on a scale relative to type of practice and on a reasonable rate of premium. I am a psychiatrist; my present premium is $1,500 that would be 1% of $150,000 gross — if at all possible. Please do not exceed that level of cost. I cannot work harder than I am (65-70 hours per week) fifty weeks per year.

Thank you.

Sincerely, John C. Morris MD

General Surgery
J. K. Johnson, M.D.
G. B. Murphy, Jr., M.D.
D. O. Montgomery, M.D.

Psychiatry
John C. Morris, M.D.

Obstetrics - Gynecology
J. M. Ribar, M.D.
J. A. Worrall, M.D.
J. N. Bertelson, M.D.
Dorris K. Heilman, M.D.

Ophthalmology
G. W. Sullenger, M.D.

Internal Medicine
G. W. Straatsma, M.D.
G. L. Walkup, M.D.

Radiology
Abram Cannon, M.D.

General Practice
J. M. Ribar, M.D.
R. D. Hanek, M.D.
C. W. Townsend, M.D.
H. E. Merz, M.D.

Pediatrics
N. F. Deely, M.D.
H. J. Jordan, M.D.

Urology
R. W. Taylor, M.D.

Orthopedics
E. Lindig, M.D.
P. B. Haggland, M.D.
F. Kelly, M.D.

Administration
J. P. Colwell
J. R. Hlinka

A PROFESSIONAL CORPORATION

February 24, 1976

Honorable Jalmar M. Kerttula
Chairman
Senate Commerce Committee
Pouch "V"
State Capitol Building
Juneau, Alaska 99811

Re: CSSB 651

Dear Senator Kerttula:

Director Block was kind enough to provide me with an advance copy of the draft language that he had suggested to your committee for inclusion in Sec. 21.88.170 of the subject malpractice bill, which was found on page 22 of the bill as originally introduced. I have sent that to the American Life Insurance Association and urged them to seriously consider whether this amendment to the bill would allow life insurance companies to be members of the proposed Joint Underwriting Association, without violating the laws of their states of incorporation. The staff of the Association has carefully reviewed the proposal in the hope that we would be able to cooperate in framing language that would avoid the problems that I brought to your committee's attention in earlier letters and testimony. They have concluded that there is no apparent way in which life insurance companies can be members of a JUA such as the one proposed, consistent with the laws under which they must operate from the states in which they are incorporated. I will set out the reasons that this is so.

It is clear from the bill that the Joint Underwriting Association is intended to write malpractice insurance. The purpose of the association is stated as being "to provide a market for malpractice insurance to the corporation . . ." Of course, it is a writing of insurance slightly different than that which goes on on the open market, in that the statute would provide that no profit could be made on such insurance, and would further provide some attempted guarantees that the insurance companies would not suffer permanent loss by participating in the JUA. Nevertheless, the entire reason for being of the Joint Underwriting Association, is to provide a substitute for voluntary, open market, reinsurance contracts. The life insurance companies, which are expressly prohibited in most states of incorporation from writing any casualty insurance in any jurisdiction, cannot do indirectly what they are prohibited from doing directly.

One of the strongest underlying policy bases for statutes prohibiting life insurance companies from writing casualty insurance, is to insulate the life insurance companies and their policyholders from the less predictable fluctuations inherent in liability insurance. All states, including Alaska, set up separate, detailed, and very conservative, reserve and underwriting laws for life companies, and the integrity of that system could be seriously affected if life insurance companies were in any way involved in casualty insurance. I point this out, not to suggest that writing casualty insurance would be any less a violation of the law for those companies if they did not incur losses, because a violation of the law would still be a violation of the law, but simply to indicate where the law had its origin. Nevertheless, it is also true that the bill now before you would have the potential of affecting the reserves and surplus of life insurance companies in the way anticipated by such statutes.

We realize that every attempt has been made in Senate Bill 651 to minimize the chance that a member company will incur a permanent loss by reason of membership in the JUA. But if it were true that the bill provided absolute guarantees that there would be no long-term loss, then no one should really mind if the life insurance companies are exempted, since (a) their participation would not increase or decrease the cost burden on any company, at least not for any length of time, and (b) the life insurance companies have no experience or management expertise in casualty insurance, and would, therefore, add nothing in the way of management ability to the board of directors. In fact, the JUA would have no reason for existence, as compared with a simple mechanism to assess premiums against health care providers, except for the fact that the member companies are obligated to loan money from their surplus accounts to underwrite malpractice insurance losses. Every attempt is made to allow eventual recoupment of those losses, by authorizing increased premiums in following years and authorizing pass through of the assessments made against the companies as taxes, to the holders of the companies' contracts of insurance. But the increased premiums, being one year or more behind, may never cancel out all borrowings. And whether the assessments can be passed on to holders of contracts depends upon market conditions and is not wholly within the control of the companies. What is sought, then, is a guarantee that JUA member companies, including life companies, will ultimately subsidize malpractice insurance if that becomes necessary. That may be a sound policy for those who are legally allowed to subsidize or to write casualty insurance. Life insurance reserves and surplus have been and are insulated from swings in casualty insurance experience, for good reason, by the law of a majority of our sister states. Such companies cannot participate in this Joint Underwriting Association.

It would be erroneous to compare inclusion of life companies in this proposed JUA with insolvency assessments under the Alaska Insurance Guaranty Association Statute, AS 21.80.010 et seq. That statute, and specifically AS 21.80-.020 and 21.80.180(6), exempts life insurance companies from

participating in that association. The National Association of Insurance Commissioners has drafted two separate solvency guarantee bills, one of which will include life companies and one of which will include casualty companies. I am told by the staff of the American Life Insurance Association that no state assesses life companies for casualty company failures, or vice versa. In the case of insolvency pools, or insurance guarantee associations, then, we have another example of the insulation of the life insurance business from the quite different and more volatile casualty insurance business. This deep-seated policy of the law is the undoubted basis of Dr. Denenberg's testimony that life insurance companies should be excluded from any malpractice underwriting association.

The life companies, the American Life Insurance Association, and this firm, have always attempted to work cooperatively with Director Block, his predecessors, and the Legislature in resolving problems arising within the insurance industry. If the present problem could be resolved by charter amendments, even by companies not incorporated in Alaska, I am sure that many of those companies would be willing to consider such charter amendments in order to be able to write insurance in this state. What this proposed JUA provision would require, however, is the repeal or amendment of long-standing state insurance code provisions in New York and approximately thirty-five other states. Even if that were possible or reasonable, until it was accomplished, the life insurance companies now writing insurance in Alaska would be faced with repeated and continuing violations of the respective insurance codes under which they are incorporated. We ask that you remove them from that untenable position.

Very truly yours,

M. T. THOMAS

MTT:kh

cc: Committee Members

RECEIVED
M.
ROGER
EAST

POLICY STATEMENT

SOUTHERN ALASKA LIFE UNDERWRITERS ASSOCIATION

ALASKA GENERAL AGENTS AND MANAGERS ASSOCIATION

ALASKA SOCIETY OF CHARTERED LIFE UNDERWRITERS

Subject: HB 594, SB 651 and other similar bills on Malpractice Insurance

Legislation forming joint underwriting associations for medical malpractice insurance and including life insurance companies writing disability coverage is pending before the state legislature. Although we recognize there are many serious problems with providing adequate malpractice insurance coverage, we are opposed to life insurance companies who write disability insurance being included in the joint underwriting association. Life insurance companies do not write property and casualty insurance. In most, if not all cases, life insurance company charters prohibit the writing of property and casualty insurance. Including life insurance companies in malpractice joint underwriting associations will create a conflict of law situation between the State of Alaska and the states where various life insurance companies are domiciled.

Further we oppose the inclusion of life companies as we do not believe that it is fair to force life companies into a joint underwriting situation for property and casualty is a clear and distinct different field of insurance. It is the same as forcing an auto insurance company to enter a joint underwriting association for life insurance.

We believe that life companies are willing to take their share of the burden of an emergency nature relating to life insurance or to disability insurance.

To the best of our knowledge no state has enacted a law bringing life insurance companies into the medical malpractice joint underwriting associations. Several have introduced legislation along that line but all have exempted life companies. We do not fully know what the reaction of the life companies will be to such an inclusion. It may be they will withdraw entirely from operating in Alaska or they may withdraw from writing disability coverages. In either case the market for Alaska citizens to purchase life insurance or disability coverages will be substantially limited if the companies follow either position. We know the companies are in opposition to this type of legislation but are not certain as to the action which they will take.

file Malpractice

VALLEY HOSPITAL
BOX H
PALMER, ALASKA 99645

March 9, 1976

Al Ose
Alaska State House of Representatives
Pouch V
Juneau, Alaska 99801

Dear Al:

Thank you for the opportunity to express our thoughts on CSHB574. By the time this letter reaches you a bill will probably have passed the Senate and the House and Senate versions will be before the free conference committee. We have not seen a copy of the Senate version yet but plan to acquire a copy and compare the two bills when a Senate version is available.

CSHB574 looks like a very good bill to us - it seems to have compromised most of the resistance but yet still maintained a legal structure that will assist greatly in reducing the malpractice problem. You asked specifically about the expert advisory panel protion of the bill. In talking with the physicians and the hospital's Board of Directors we feel the expert advisory panel is one of the major sections of the bill and as it is written in CSHB574 seems to be very reasonable to us. The expert advisory panel is very important as a screening mechanism. As you know, because of the contingency fee incentive attornies and unhappy patients often file a nuisance suit against a doctor or a hospital just to see if the insurance company will make a cash settlement out of court. The advisory panel provided for in CSHB574 would inform the indemnity corporation, the court, the plaintiff, and the defense whether or not there was merit to the case. The expert advisory panel would also provide the expert testimony always needed but often hard to get in malpractice cases. The expert advisory panel is a very important cost containment mechanism that we feel is necessary in controlling premium costs.

There are a number of other topics we would like to see covered in CSHB574 but we understand that we can't have everything so we would like to heartily endorse and support the bill as it is in its present form.

There are two physicians in Juneau presently representing the Alaska State Medical Association (Richard Witt, M.D. and Rodman Wilson, M.D.) that the physicians and hospital here respect and trust greatly as a voice for Alaskan hospitals and medicine. Both have studied the malpractice problem extensively and we feel have concern for the public as well as the health professions in their work to acquire a solution to our malpractice insurance dilemma. We hope that you will get to know these two individuals so that they may express to you our concerns in the malpractice insurance issue.

Thank you again.

Sincerely,

Robert G. Ogden
Administrator

RGO/kh

J

A PROFESSIONAL CORPORATION

February 4, 1976

Honorable Jalmar M. Kerttula
Chairman
Senate Commerce Committee
Pouch "V"
State Capitol Building
Juneau, Alaska 99811

Re: Membership of Life Insurance Companies in Joint Underwriting Associations

Dear Senator Kerttula:

When I appeared briefly before your committee last Saturday morning, I said that I would provide you more solid information concerning the nature of the legal impediments to JUA membership faced by life insurance companies, and the impact of that problem on the State of Alaska. This letter is to provide that additional information.

Commerce Department figures indicate that the five largest writers of disability insurance in the State of Alaska, among life insurance companies, were Aetna, Occidental, Travelers, New York Life, and United Benefit. Among them, they wrote premiums approximating 10 million dollars in 1972. In 1974, the five largest were Aetna, Continental, Pacific Mutual, Travelers, and New York Life, and those companies wrote approximately 11 million

dollars in disability premiums. In 1972, the last year for which the American Life Insurance Association has fairly complete figures, life insurance companies wrote a total of approximately 19 to 20 million dollars in disability premiums, compared to disability premiums by casualty companies of approximately 1.6 million dollars.

Approximately thirty-six states do not permit domestically incorporated life and health insurance companies to write casualty insurance, including malpractice insurance. Some of those statutes are very explicit in prohibiting the writing of casualty insurance by a company incorporated in their state, whether that insurance is written inside or outside the state of incorporation. Some other state statutes are not completely clear on the point, or are silent, but it is the opinion of the Association that in thirty-six states, the domestic companies are not free to write casualty insurance. To give specific examples relating to companies writing substantial insurance in Alaska, the New York Life Insurance Company is a domiciliary of New York. The New York Insurance Code, Sections 46 and 193, prohibit a life insurance company domiciled there from writing casualty insurance. The Continental Life Insurance Company is incorporated in Illinois, and Sections 616, 621, 651 and 720 of Chapter 73 of the Illinois Code, read together, likewise prohibit the transacting of casualty insurance business by life insurance companies domiciled there.

In response to your question as to what concessions have been made by life insurance companies in other states when responding to proposed legislation of this kind, I am told by the counsel for the American Life Insurance Association that Alaska is the first state to seriously consider inclusion of life insurance companies in Joint Underwriting Associations as a condition of doing business, and so the member companies and the Association have never been put in this position before.

I have spoken to Director Block concerning this problem since your hearing of last Saturday morning, and I understand that he did not believe that there was a

difference between the position that the life insurance companies find themselves in and that of Blue Cross. In the case of Blue Cross, it is apparently true that the company writing insurance in Alaska is domiciled in Washington, and apparently the company has made the determination that under Washington statutes they would be able to amend their charter or take other corrective action in order to be able to participate in a Joint Underwriting Association. That is not true of the life insurance companies, which are almost always incorporated in one state only, and simply admitted to write insurance in the remaining states. They are, of course, subject to the statutes and regulations of their domiciliary states, and as you have seen by the examples given above, that legal control of the domiciliary state extends to business written in Alaska or anywhere else.

I also understand that Director Block believed that the act of belonging to this proposed Joint Underwriting Association might not be the same as writing malpractice insurance, since he viewed membership in the Association as simply a method of exacting assessments, and not the writing of insurance as such. I cannot say whether calling the business transacted by the Joint Underwriting Association by a different name would in fact change the legal result, and I will seek further clarification from the Association on that point. It certainly is true, however, that as the bill is now drafted, the Joint Underwriting Association is set up explicitly to write re-insurance for the malpractice indemnity corporation, and I believe that Director Block agrees that as written the bill presents substantial problems, of the kind that I have been describing, to the company.

Although I was not present when Dr. Denenberg gave his recent testimony on malpractice matters, I understand that he recommended that life insurers not be included in any pooling or Joint Underwriting Association. The problems inherent in attempting to do so might, to a very large extent, offset the benefit of the proposed legislation, if it endangers the legal right and ability of life insurance companies to do business in this state. We are very sensitive to the fact that this is the same problem that was brought

to your attention last year, and that one of the entities complaining the loudest, namely Blue Cross, has now reconsidered and come to a different conclusion. We can only say that, with regard to the life insurance companies, the problem is very real, cannot be resolved by amendment of company charters, and deserves very careful consideration. I am sure that you and your Committee will give it that consideration, and I would, of course, be pleased to provide any further information that may be helpful.

Very truly yours,

M. T. THOMAS

MTT:kh

POLICY STATEMENT

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ALASKA GENERAL AGENTS AND MANAGERS ASSOCIATION

ALASKA SOCIETY OF CHARTERED LIFE UNDERWRITERS

Subject: HB 594, SB 651 and other similar bills on Malpractice Insurance

Legislation forming joint underwriting associations for medical malpractice insurance and including life insurance companies writing disability coverage is pending before the state legislature. Although we recognize there are many serious problems with providing adequate malpractice insurance coverage, we are opposed to life insurance companies who write disability insurance being included in the joint underwriting association. Life insurance companies do not write property and casualty insurance. In most, if not all cases, life insurance company charters prohibit the writing of property and casualty insurance. Including life insurance companies in malpractice joint underwriting associations will create a conflict of law situation between the State of Alaska and the states where various life insurance companies are domiciled.

Further we oppose the inclusion of life companies as we do not believe that it is fair to force life companies into a joint underwriting situation for property and casualty is a clear and distinct different field of insurance. It is the same as forcing an auto insurance company to enter a joint underwriting association for life insurance.

We believe that life companies are willing to take their share of the burden of an emergency nature relating to life insurance or to disability insurance.

To the best of our knowledge no state has enacted a law bringing life insurance companies into the medical malpractice joint underwriting associations. Several have introduced legislation along that line but all have exempted life companies. We do not fully know what the reaction of the life companies will be to such an inclusion. It may be they will withdraw entirely from operating in Alaska or they may withdraw from writing disability coverages. In either case the market for Alaska citizens to purchase life insurance or disability coverages will be substantially limited if the companies follow either position. We know the companies are in opposition to this type of legislation but are not certain as to the action which they will take.

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JOHN E. KOLSTOE, CLU
MEMBER, MILLION DOLLAR ROUND TABLE
NATIONAL QUALITY AWARD

BOX AJ . . . . PALMER, ALASKA 99645
BUS: 745-3230 · RES: 745-3840

NEW YORK LIFE INSURANCE COMPANY

LIFE, HEALTH, GROUP INSURANCE,
ANNUITIES, PENSION PLANS

March 1, 1976

Rep. Nels Anderson Jr.
D-Dillingham, Room 118 Capitol
Juneau, Alaska 99801

Dear Rep. Anderson:

On the various proposals having to do with solving the medical mal-practice problem in Alaska there has been some suggestion of an insurance pool having all insurance companies licensed to do business with the state of Alaska sharing in the mal-practice risk specifically HB 594, SB 651.

I vigorously protest any such action and ask you to do what ever you can to impede such a move. While there may be a certain superficial appeal to such action it would not serve to the best interest of Alaska or Alaskans.

The many different fields of insurance are highly specilized. Most life insurance companies do no business what so ever in casualty or liability insurance which would include mal-practice. They do not have the facilities for this, they do not have the expertise nor the experience for such considerations.

Many large insurance companies such, as the New York Life which I represent, would be faced with a very serious diliemna should such an enactment come to be. My company and many others like it would be faced with a choice of entering into a business about which it has no interest and has no experience or knowledge, or discontining health and disability coverage, or removing itself from the state altogether. The likelihood is that several insurance companies would simply cease to do business in Alaska if the price for doing business here was also to be involved in medical mal-practice insurance. The results would be essentially as follows:

1. Thousands of Alaskans would be denied the opportunity to obtain life insurance coverage because of the sudden removal of several large insurance companies from the state.

2. The premium tax generated by these companies (which amounts to a considerable amount of revenue every year) would no longer be available to the state of Alaska.

3. The millions of dollars of investment capital which these companies invest in Alaska each year would undoubtably be curtailed.

4. Management and office personnel currently living in Alaska would find their offices closed.

5. Personally I would be faced with an unpleasant choice of either leaving my company or leaving Alaska. Neither of which appeals to me.

It is for these above captioned reasons that I would respectfully submit that you would take vigorous steps to be sure that the burden of the medical malpractice problems is not placed on the backs of life insurance companies where it does not belong.

Respectfully,

John E. Kolstoe

John E. Kolstoe, C.L.U.

JEK/lc
enclosure

P.S. I have enclosed a copy of a policy statement endorsed by three groups actively involved in the life insurance industry.

JOHN E. KOLSTOE, CLU
MEMBER MILLION DOLLAR ROUND TABLE
NATIONAL QUALITY AWARD

BOX AJ PALMER ALASKA 99645
Bus. 745-3230 · Res. 745-3840

NEW YORK LIFE INSURANCE COMPANY

LIFE, HEALTH, GROUP INSURANCE,
ANNUITIES, PENSION PLANS

March 3, 1976

Rep. Al Ose
D-Palmer
Room 203A Assembly Bldg.
Juneau, Alaska 99801

Dear Rep. Ose:

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John E. Kolstoe, C.L.U.

JEK/lc
enclosure

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JOHN E. KOISTOE, CLU
MEMBER MILLION DOLLAR ROUND TABLE
NATIONAL QUALITY AWARD

BOX AJ PALMER, ALASKA 99645
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NEW YORK LIFE INSURANCE COMPANY

LIFE, HEALTH, GROUP INSURANCE,
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4. Management and office personnel currently living in Alaska would find their offices closed.

5. Personally I would be faced with the unpleasant choice of either leaving my company or leaving Alaska. Neither of which appeals to me.

It is for these above captioned reasons that I would respectfully submit that you would take vigorous steps to be sure that the burden of the medical mal-practice problems is not placed on the backs of the life insurance companies where it does not belong.

Respectfully,

John E. Kolstoe, C.L.U.

JEK/lc
enclosure

P.S. I have enclosed a copy of a policy statement endorsed by three groups actively involved in the life insurance industry.

HB

574

file Malpractice

Alaska House of Representatives

POUCH V
JUNEAU
99811

P. O. BOX 9
KENAI
99611

HUGH MALONE

27 February 19 6

The Honorable Mike Bradner
Speaker of the House
Alaska State Legislature

Dear Mr. Speaker:

The House Finance Committee has reviewed Article 3 of CSHB 574. This article provides for the establishment of a revolving loan fund in the Department of Commerce and Economic Development, for the purpose of making loans to the medical insurance corporation established in the bill.

The loans would be made by the Department of Revenue from the General Fund. The loans under the section would be at seven percent interest for a maximum period of four years. The maximum that could be borrowed is $5 million. The loans are secured with corporation pledges.

The Committee examined the impact of Article 3 on the State's General Fund cash flow.

Testimony from the Department of Revenue indicates that whatever the amount of any loan, the effect on the General Fund is the same as an appropriation. The money is gone. The Department suggested an appropriation would be a more straightforward approach. Also, since a negative cash flow is projected for the state for a period before June 30, 1977, the amount loaned out will require increased short-term borrowing by the state ($125 million now projected).

The House Finance Committee recommends the loan fund approach. The reasons are:

1) The amount of the loan would be very small compared with existing loan programs, e.g. the V.A. loan program "runs out" of the general fund approximately $4 million per month.

2) Data from the House Judiciary Committee indicates malpractice insurance claims paid in Alaska average less than $500,000 per year, while premiums run in excess of $1 million. Thus the probability of ever using the maximum loan authorization is very small.

DATA ARE PLURAL

3) A loan is much more likely to be repaid than an appropriation and is much less of a subsidy.

I hope the information is useful to the House.

Sincerely,

Hugh Malone

HM/jb

File Malpractice

Malpractice Advisory

A year ago, the malpractice crisis was officially recognized nationwide. The St. Paul (Minn.) Fire and Marine Insurance Company was threatening to leave Maryland and Argonaut Insurance Company was getting ready to pull out of New York. Premiums were doubling and even tripling not only in states like California and Florida where the numbers of suits were multiplying and the dollar amounts of individual awards and settlements were topping $1 million, but also in states like Indiana and North Carolina where suits and high awards were relatively rare. In Michigan, two long-time carriers, Medical Protective and Shelby Mutual, were refusing to write new policies, although they still would insure old customers. It looked like a grim year ahead.

It was, and the outlook for 1976 is worse. St. Paul did, in fact, pull out of Maryland and Argonaut did withdraw from New York. Not only that, but St. Paul has in the past 12 months left 16 other states and Argonaut has pulled out or attempted to leave all states where it was the major carrier, including California, Florida, Idaho, Massachusetts, and Pennsylvania. (It may stay in Hawaii, where it makes a profit.)

MALPRACTICE: GRIM OUTLOOK FOR '76

No doctor can count any longer on finding policies at stable prices



Dr. Hedges at Juneau boat harbor

Several other major insurers, as of January 1975, such as Employers Insurance of Wausau and Lloyds of London, have either voluntarily dropped completely out of the malpractice insurance business or—like Signal Imperial of Los Angeles—have been forced out because of insolvency. About the only big companies writing new policies in more than a single state as 1976 got under way were St. Paul (only in the 33 states that will allow its controversial claims-made form), Medical Protective, Travelers, Hartford, and Aetna.

The list of states with problems either of availability or of exorbitant rates (anything under $10,000 for the highest risk categories is now viewed by many doctors as "cheap") has grown to include all but a handful—specifically Colorado, Georgia, Nebraska, and Oklahoma. Even in these states physicians are uneasy about their future.

Things have gotten so bad for Alaska's 270 physicians that about 30% of them are practicing without malpractice insurance. Doctors in Orange County in southern California are talking of going without insurance en masse if Travelers raises its premiums several hundred per cent this month, rates that would put orthopedists and neurosurgeons in the class paying $36,239. Other southern California doctors have threatened slowdowns if the situation doesn't improve.

Dr. Gary R. Hedges, a Juneau general surgeon who this year is president of the Alaska State Medical Association, says 13 of his city's 16 physicians—including himself—are practicing without professional liability insurance. The only new policies available, he says, are claims-made forms that, unlike St. Paul's, don't even guarantee "tail-end" policies for doctors who retire or switch plans.

"I'm not worse off without any insurance than I'd be with a policy like that," says Dr.

continued

MALPRACTICE LAWS IN THE 50 STATES AS OF YEAR'S END

(Entries printed in color denote proposed legislation not yet enacted)

*= proposed legislation *= Current laws

	Joint Underwriters Association	Self-insurance Plan	State Insurance Fund	Screening Committee or Arbitration (binding, unbinding)	Limit on Doctor's Liability ($'s 1,000)	MD-financed Catastrophic Fund	Tort Law Changes	Statute of Limitations (years after incident)	Limit on Lawyers' Fees (%)	Study Commission Established	Insurer Reports Claims to State Insurance Commissioner or Board of Medical Examiners	Major Insurance Carrier	Major Carrier's Rates for Orthopedists ($100,000/$300,000) (boldface denotes claims-made) 1/1/75	(1/1/76)	Legislature Meets	Comment
Alabama	★			★			★	2			★	Employers of Wausau	$1,692	($2,606)	5/4/76	Wausau withdrawing July 1977; ISO proposes rates up to $9,000.
Alaska	★		★	★		★	★	3	★[1]	★	★	Continental	$4,172	($4,172)	1/7/76	About 30% of doctors have no policies; individual premiums up to $40,000.
Arizona	★	★		★	★	★	★	2	N.J.[2]	★	★	Travelers	$3,621	($6,521)	1/13/76	Travelers withdrawing April 1976; Imperial in receivership; no other in sight.
Arkansas	★			★	500	★	★	2	N.J.			St. Paul	$1,686	($2,426)	1/12/76	Medical society hearing of more and larger malpractice suits.
California	★	★		★	★[3]		★	3	N.J.		★	Travelers	$7,200	($36,239)[4]	1/5/76	'Cataclysm' (due to price increases) expected in southern Calif. this month.
Colorado	★	★						2		★		Hartford	$3,122	($3,590)	1/7/76	Legislative thrust is strengthening board of medical examiners.
Connecticut					500		★	3	N.J.	★		Aetna	$5,258	($7,511)[5]	2/4/76	Doctors in droves joining medical society, which has state's only insurance plan.
Delaware	★			★			★	3	N.J.		★	Aetna	$6,297	($11,010)[5]	1/13/76	All of state's seven hospitals may lose coverage at end of year.
Florida	★	★		★	100	★	★	4		★	★	Self-insurance plan	$8,243	($8,243)[6]	4/6/76	Argonaut withdraws Jan. 1; self-insurance plan has 2,500 applicants.
Georgia	★			★			★	3		★		St. Paul	$1,530	($1,760)	1/12/76	Situation is stable.
Hawaii	★	★		★			★	6	N.J.	★	★	Argonaut	$5,616	($6,884)	1/21/76	Argonaut wants to remain in Hawaii, only state it makes a profit in.
Idaho	★	★			150[7]		★[7]					St. Paul	$3,748	($2,054)[8]	1/12/76	State court ruled doctor's $150,000 liability limit unconstitutional.
Illinois	★	★		★[7]	500[7]		★	5	★	★		Hartford	$3,468	($5,084)	1/14/76	State court ruled liability limits and screening panels unconstitutional.
Indiana		★	★	★	100	★	★	2	15[9]	★	★	Medical Protective	$2,903	($3,289)	1/5/76	New law hasn't appreciably changed malpractice picture in Indiana.
Iowa	★			★	100	★	★	6	★[1]	★		Medical Protective	$1,535	($3,400)	1/12/76	Medical society wants to strengthen board of medical examiners.
Kansas	★			★	100	★	★	2	N.J.	★	★	Medical Protective	$1,810	($3,07[illegible]	1/13/76	Many individual physicians paying close to or in excess of $10,000.
Kentucky	★				100	★	★	5	N.J.		★	Medical Protective	$1,823	($3,304)	1/6/76	Governor's task force will propose comprehensive package of bills.
Louisiana			★	★	100	★	★	3	50		★	Hartford	$1,568	($5,241)	5/10/76	Society agreed Hartford correct when it cancelled policies of five doctors in 1975.
Maine	★			★	100	★	★			★	★	Hartford	$1,737	($4,754)	2/2/76	New doctors must pay up to twice ISO rates; JUA not activated yet.
Maryland	★	★		★			★	3	★		★	Self-insurance plan	$2,273	($5,038)	1/14/76	Self-insurance plan has sold 2,000 policies (there are 5,000 doctors).
Massachusetts	★	★		★	★		★	3	★	★		JUA	$2,657	($4,102)[10]	1/7/75	St. Paul withdrawing coverage from some 4,000 doctors; JUA new carrier.
Michigan		★	★	★			★	2½	N.J.[11]	★	★	Medical Protective	$5,551	($7,863)	1/14/76	ISO has filed new premium rates up to $34,883 for orthopedists.
Minnesota				★[11]			★				★	St. Paul	$2,196	($2,630)	1/26/76	Medical society wants to strengthen board of medical examiners.
Mississippi	★	★		★			★	2				St. Paul	$924	($916)	1/6/76	USF&G charging up to $8,000, apparently to drive doctors to St. Paul.
Missouri	★	★		★	500		★	2	33⅓	★	★	Medical Protective	$2,200	($3,300)	1/7/76	State-sponsored program with Marine Fire

Montana		★[12]						3		★		Aetna	$7,504	($13,287)[5]	1/3/77	Coverage is available although premiums considered high.
Nebraska		★[12]		★			★			★		St. Paul	$2,586	($3,010)	1/6/76	'As of today, there's no crisis,' according to state medical society.
Nevada	★			★	★		★	4	N.J.	★		JUA	$5,136[13]	($7,675)	1/17/77	As many as 25% of Nevada doctors practicing without insurance.
New Hampshire	★			★			★	2		★		Hartford	$466	($1,693)	1/5/77	'Prognosis' a lot better here than in neighboring states.
New Jersey			★	★	500		★	2	N.J.[11]	★		Chubb & Son	$6,325	($8,165)	1/13/76	Still a voluntary insurance market in New Jersey.
New Mexico	★	★		★	100	★	★	3	N.J.			Travelers	$3,315	($5,781)[14]	1/20/76	Travelers, withdrawing March 1, insures 90% of state's doctors (850).
New York	★	★	★	★[11]	★		★	2	N.J.	★		JUA–self-insurance plan	$14,329	($17,195)[4]	1/7/76	Self-insurance company expects to lower rates; already has 15,000 members.
North Carolina	★[7]	★		★	★	★	★	★				St. Paul	$971	($1,251)	1/12/77	Self-insurance plan has 400 of state's 4,700 doctors as members.
North Dakota		★[12]		★	50[9]	★	★	2	15[16]			St. Paul	$1,819	($899)	1/4/77	Some problems insuring new doctors; companies selective.
Ohio	★			★			★	1	33⅓	★		Medical Protective	$5,148	($5,834)	1/1/76	Doctors disappointed tort reforms did not immediately lower premiums.
Oklahoma					150		★	4	N.J.			Ins. Co. of North America	$1,180	($1,594)	1/6/76	Only INA writing policies, but most doctors can buy insurance.
Oregon		★			★[17]	★	★	5	33⅓	★	★	CNA conglomerate	$3,016	($7,240)	1/10/77	Must renegotiate expiring contract with CNA by end of the year.
Pennsylvania	★			★		★	★	4[18]	N.J.	★	★	Medical Protective	$3,035	($5,957)	1/6/76	With $1-million 'umbrella' coverage, some doctors pay up to $18,000.
Rhode Island	★[11]									★		JUA	$1,209	($5,838)	1/6/76	JUA rates considered exorbitant by doctors, but no other policies available.
South Carolina	★			★	★		★	★		★		JUA	$1,010	($1,716)	1/13/76	St. Paul withdrawing; all doctors must buy policies from JUA.
South Dakota	★	★[12]		★			★	2		★	★	St. Paul	$6,428	($2,087)	1/6/76	Medical society fears exclusive JUA would be 'disaster' if imposed.
Tennessee	★	★		★			★	3	33⅓		★	JUA	$3,129	($12,509)	1/13/76	Shelby Mutual leaving, doctors must buy policies now from the JUA.
Texas	★			★	500		★	2	N.J.	★	★	Medical Protective	$4,065	($6,728)	1/11/77	Houston orthopedists buying basic policy from JUA, plus $1-million excess coverage, pays $26,900.
Utah	★				250		★	4		★		Aetna	$6,186	($10,603)[5]	1/12/76	For 1-year extension, Aetna requires medical society support of new laws.
Vermont				★			★	4	N.J.			Aetna	$4,430	($11,925)[5]	1/6/76	Aetna will pull out if new rates not approved; covers 450 MDs (50%).
Virginia	★	★	★	★	100	★	★	2	15[16]	★	★	St. Paul	$2,728	($3,432)	1/14/76	Availability not a problem, but doctors must pay double for $1 million.
Washington	★			★	300		★	2	N.J.		★	Aetna	$6,356	($10,847)[5]	1/12/76	Will try to get mandatory, binding arbitration next year.
West Virginia	★			★	100	★	★	2	N.J.	★	★	Aetna	$6,575	($10,583)[5]	1/14/76	Aetna only company writing new business in the state.
Wisconsin	★			★	200	★	★	3		★		Medical Protective	$2,433	($3,032)	1/20/76	'Over the hump but still an expensive proposition.' Orthopedists pay up to $11,000.
Wyoming	★	★[12]		★	100	★	★	2	N.J.	★	★	Aetna	$1,899	($7,865)[5]	1/27/76	St. Paul pulled out in June but Aetna picked up most of 120 doctors.

[1]Court decides fees. N.J. denotes so-called New Jersey rule, based on a sliding scale. In New Jersey, it is as follows: 40% on first $5,000, 33⅓% on next $45,000, 20% on next $50,000, 10% of anything over $100,000. [2]$250,000 limit on noneconomic damages (pain and suffering). [3]Provides $1 million/$3 million compared with same coverage by Argonaut on Jan. 1, 1975. [4]Aetna's package plan provides $1.25 million/$1.6 million coverage for orthopedists, plus several other features. [5]Provides $500,000 coverage per claim with no aggregate, compared with $100,000/$300,000 by Argonaut on Jan. 1, 1975. [6]Ruled unconstitutional by lower state court. [7]Provides $150,000/$300,000 compared with $100,000/$300,000 by Argonaut on Jan. 1, 1975. [8]On fees collected from catastrophic fund. [9]Rate hearings in late November may result in increased rates by Jan. 1, 1976. [11]Nonstatutory. [12]Five-state regional self-insurance plan proposed. Of these five states only North Dakota has passed law authorizing self-insurance. [13]Imperial's charge on Jan. 1, 1975 for $1 million/$1 million minimum policy it wrote for Nevada orthopedists before going into receivership. JUA rate is for $100,000/$300,000. [14]Provides $1 million/$1 million package compared with $1 million/$1.3 million by Travelers on Jan. 1, 1975. [15]State currently has six-year statute of limitations. [16]Of awards over $100,000. [17]Class 1 and 2: $100,000; Class 3 and 4: $300,000; Class 5 and 6: $500,000. [18] Limit on insurance company liability only.

Hedges, who decided against paying $8,000 for $300,000 maximum coverage in January of last year. A previous $900,000 suit, initiated during a period when he had coverage, has been dropped and—so far—he has had no other malpractice suits lodged against him. He says he informs his patients of his lack of coverage, telling them it's for their benefit as well as his.

"I would have been forced to raise my fees," says Dr. Hedges. And patients paying the higher fees, he maintains, would have assumed his coverage would be sufficient to help them should injury occur. "This would have been doubly misleading," he explains, "because I'm still not sure I'd have coverage" that is either adequate or perhaps even available in the event a patient sued after the coverage expired.

In California, a group of physicians' wives calling themselves Women for Malpractice Reform staged a sleep-in last month at the Sacramento offices of Gov. Edmund G. Brown Jr. to protest rising malpractice rates and demand an emergency session of the legislature to find an acceptable solution to the problem. Roberta Weintraub, wife of Encino, Calif., proctologist Lewis R. Weintraub, presented Governor Brown with 350,000 petitions signed by patients. She declared that 45% of the state's physicians would stop practice if he failed to act.

Early returns indicated that the threatened "slowdown" of southern California doctors would not be effective. Leon Hauck, director of association services of the Hospital Council of Southern California, said only "a few guys" in about ten of southern California's 230 hospitals had taken any action. The job action was predicted to become more widespread once rates increased at the beginning of the year, however.

How bad is the problem nationwide? A 50-state survey by MWN reveals deterioration in almost every state, even in some of those that passed comprehensive malpractice legislation during 1975. Among the states deserted by St. Paul, for example, are two besides Maryland where it was the major carrier with at least 50% of the business—Massachusetts and South Carolina. The firm quit another—Rhode Island—where it had close to half the market. St. Paul was the second largest carrier in Indiana and New Jersey, which have been similarly abandoned.

And premiums indeed have increased. Rates filed by the Insurance Services Organization (ISO) for its member companies have raised the malpractice insurance cost for orthopedists and other high-risk specialists buying $1-million policies (where they can get them) to as much as $10,000 and more in previously "low cost" states like Alabama, Hawaii, Kansas, and Montana. In "expensive" states like California and Michigan, many of the same high-risk specialists pay more than $30,000 for the same policies—again, when they can find them.

Physicians in a few states have experienced little trouble yet with either availability or price of medical malpractice policies. But medical society officials in these states express concern for the future. "We're not at the crisis stage," a Colorado Medical Society spokesman told MWN, "we're at the problem stage." Said an Oklahoma State Medical Association official: "We're doing well, but we're being affected by the national situation." His major concern, he added, was that only one company—Insurance Company of North America—writes malpractice policies in Oklahoma. If it ever decided to pull out, he added, Oklahoma doctors would be in the same pickle as those in dozens of other states.

Last year, some 22 states trying to seize the bull by the horns passed—among other "malpractice" bills—legislation creating Joint Underwriters Associations (JUAs) that would sell malpractice insurance to doctors as a last resort when no other market existed. In fact, JUAs are the only source of malpractice coverage currently in four states—Nevada, Rhode Island, South Carolina, and Tennessee—and compete only with doctors' self-insurance plans in two others, New York and Florida.

Yet even where they are the only game in town, JUAs have been criticized by doctors, primarily for their high rates compared with those the doctors were used to. In Rhode Island, where physicians have had to pay more than quadruple what they previously had been paying, the state's nonstatutory JUA is highly unpopular. The medical society's executive director, Timothy B. Norbeck, told MWN that physicians felt the "rates were exorbitant." He pointed out, however, that high as they were, the JUA rates in Rhode Island were really comparable to those in other northeastern states (see table, pages 72 and 73). Part of the reason for the high rates, he said, was the JUA's requirement for a "stabilization fund" that added about 25% to the first year's basic premiums.

High price, however, is not the only flaw with JUAs. Most of the ones now in operation limit coverage to between $100,000 and $200,000 per claim and from $300,000 to $600,000 aggregate per year, leaving many doctors feeling dangerously exposed. But where nothing else is available, physicians—like beggars—have little choice.

Another problem with JUAs: Where they are authorized, teetering malpractice carriers sometimes use the fact as an excuse to pull out. This apparently was the case in both South Carolina and Massachusetts when St. Paul decided to withdraw, knowing criticism of its departure would be dampened by the existence of an alternative source of malpractice insurance. St. Paul was roundly condemned in Maryland when it threatened to pull out of that state early last year, ultimately delaying its departure several times until another source could be established (the medical society's self-insurance plan). Similarly, Argonaut found itself cast as a villain when it dumped thousands of physicians in New York, California, Florida, and Pennsylvania early last year. (After court suits, it stayed on for a time in those states.)

Another fear of many state medical society officials is that few of the remaining commercial malpractice insurers will return to states that have actually established JUAs—usually for only a two-year period—as an "exclusive market" for professional liability insurance, as have Rhode Island, South Carolina, and Tennessee. This fear prompted Robert D. Johnson, executive secretary of the South Dakota State Medical Association, to oppose crea-

continued

tion of a JUA in his state. "It could be disastrous to getting private carriers back," he told MWN.

The kind of legislation that state assemblies pass is greatly influenced by what the few remaining malpractice insurers are likely to think of it, whatever its other value in affecting the over-all malpractice situation. The landmark Indiana malpractice law was put together by the state medical society with the help of the state's two major malpractice carriers, St. Paul and Medical Protective. When St. Paul pulled out of the state anyway (after the insurance commissioner turned down its request for permission to sell the claims-made form), the medical society officials were understandably bitter.

In California, assembly speaker Leo T. McCarthy pointed out that before the state's comprehensive malpractice legislation was passed insurance companies had refused to promise how much their premiums would be reduced if specific reforms that the companies had sought were approved by the legislature. This led to a comment from one insurance industry official that "this is the sort of legislator who makes it difficult for insurers to endorse specific tort reform." What the industry wanted, apparently, was less than a *quid pro quo*.

Despite the unequal relationship, medical societies still seek "advice" from insurance companies on malpractice legislation they put together. In a few cases, the insurance firms flatly give medical societies a choice: Push for specific tort reforms (with no promises on rates or availability) or look for another carrier. Aetna, which insures up to 85% of the 1,400 doctors in Utah, told the Utah State Medical Association that its extension of the firm's package plan into 1977 was "contingent on two things," according to Hoyt W. Brewster, the medical society's executive director. "First, we had to pursue programs of physician education. And, second, we had to pursue legislative relief in terms of tort reform." With only 20 days during the short 1976 session to get any legislation through, he told MWN, he is not sure how many of the tort reforms the medical society can persuade the Utah assembly to adopt.

Feeling oppressed both by insurance company dictums and by hasty legislative solutions like JUAs, medical societies in at least ten states either have set up their own self-insurance programs or have received the authority to do so. Of these, self-insurance plans in California, Florida, Maryland, Michigan, New York, and North Carolina have already started selling policies or are building up the necessary capitalization to do so. In Florida, where 2,500 applications have been received to date, rates are the same as those Argonaut charged early last year. Not only that, the plan provides $500,000 coverage per claim—with an unlimited aggregate per year—for the price that Argonaut demanded for $100,000/$300,000 coverage.

In New York, there are already between 15,000 and 16,000 members in the self-insurance plan, which began by charging 20% over Argonaut's fee, then reduced that to 15% when reserves of $26 million were accumulated. The New York self-insurance plan now promises to reduce charges to 10% if—as expected—it builds up $30 million in reserves. In Maryland, on the other hand, even though 2,000 of the state's 5,000 physicians have already signed up with the self-insurance plan, premiums are still more than double what St. Paul was charging early last year.

Perhaps it is significant that in both Florida and New York there is active competition with the medical society's plan; in Maryland, self-insurance is all that is available.



At meeting in Governor Brown's Sacramento offices, Mrs. Weintraub (left, center) of Women for Malpractice Reform presents petitions for special session to deal with soaring rates. Below, Drs. Zorel Paritzky (left) and Stanley Daniels, who has no insurance, carry in half of 350,000 petitions.



Florida's JUA charges 2½ to three times what the self-insurance plan does. In New York, there is, in addition to the self-insurance plan, both a JUA and a state-run insurance fund that seek to sell malpractice policies to doctors. When they all started up at roughly the same time last summer, the three schemes were in hot competition. Recently, New York superintendent of insurance Thomas A. Harnett turned down the JUA's request for rate increases, forcing it to stay roughly at the same premium level as the self-insurance plan.

In Michigan, a similar state insurance fund was put into effect somewhat before the medical society's self-insurance plan got under way. In that case, another group of doctors was involved—the Michigan Physicians Crisis Committee. The organization was formed several years ago to push through the state's comprehensive malpractice law package and has not yet disbanded, somewhat to the consternation of the state medical society. The crisis committee has backed the state fund over the medical society's plan as providing more insurance coverage ($200,000/$600,000 compared with $100,000/$300,000) and criticized the medical society for trying to "cherry pick" the low-risk physicians.

In two areas of the country where individual states have too few physicians to seriously consider a medical society self-insurance plan, groups of states have looked into the possibility of establishing regional self-insurance plans. Nevada sponsored a meeting in Las Vegas recently, inviting all the smaller states of the Far West to discuss one self-insurance plan for all of them. Nebraska similarly sponsored a regional self-insurance plan for five Upper Plains states: Rep. Mary Edelen of South Dakota drafted a joint resolution for presentation to the legislative sessions in Nebraska, Wyoming, Montana, and the Dakotas this year.



Patients' plight is voiced by Gerri Weiss (left) and Janice Oliver whose California OBs, they say, won't deliver without insurance.

And in New England, according to Vermont State Medical Society executive director Getty Page, a third group of smaller states has looked into a similar arrangement, possibly hooking onto the self-insurance plan Massachusetts hopes to set up independently in the next year or so. "I pleaded with Massachusetts to let us come in with them," Page said, "but we'd have to have the same malpractice laws." To that end, the Vermont State Medical Society is introducing a comprehensive package of legislation this year (see table, pages 72 and 73).

The most popular legislative proposals likely to be introduced this year are reforms in the states' tort laws, such as elimination of *res ipsa loquitur*, which puts the burden of proof concerning lack of negligence on the doctor; prohibition of *ad damnum* pleas, which publicize multimillion-dollar lawsuits; institution of a collateral source rule to require deduction of health insurance and other reimbursements from any ultimate judgment; adoption of a local-witness rule that forbids the use of itinerant "experts"; and—most popular of all—setting short (usually two-year) statutes of limitations that begin running from date of injury rather than from date of discovery.

Every state but Colorado and Montana either has already passed more than one of these reforms or will seek to do so when assemblies reconvene. In Colorado, according to a medical society spokesman, the legislative thrust this year will to strengthen the board of medical examiners and tighten up the statute of limitations. In Montana, medical society executive director G. Brian Zins said: "We're studying what other states have done."

Not very surprising is the fact that many of the states in the most trouble intend to be the most active legislatively next year. (Colorado and Montana are in relatively good shape.) One state that has been in trouble all year is Alaska, where doctors at the state's largest hospital—Providence Hospital in Anchorage—refused to perform nonemergency surgery for almost two months when their insurance policies ran out this summer, referring many of their patients to Seattle for operations. The hospital's parent corporation, the Sisters of Providence, found them temporary insurance on September 22.

In response to such situations, the Alaska medical society has sponsored a comprehensive package of laws including creation of both a JUA and a state insurance fund, a constitutional amendment to take physicians' professional liability out of the court system (substituting arbitration), a limit of three years on physicians' liability, and elimination of awards for such noneconomic damages as "loss of consortium" and "pain and suffering." Alaska has already eliminated *res ipsa loquitur*; in fact, it led other states by several years in doing so. But the medical society's efforts last year to put through additional reforms were frustrated. Governor Jay S. Hammond refused to call a special session to deal with the package of new laws that insurance companies were unenthusiastic about and vetoed the only malpractice bill the assembly did manage to pass in 1975—one creating a JUA.

continued

Physicians complain that 'tort reform' brings no relief

Another state in serious trouble—New Mexico, where the major carrier, Travelers (which writes about 99% of the state's malpractice policies), has announced it will pull out on March 1—is also seeking to get a comprehensive package of laws through the legislature this year. A medical society spokesman said in the 30 days, starting January 20, when the state legislature is in session, doctors will attempt to get laws passed both establishing a JUA and authorizing doctors' self-insurance, an Indiana-type law with screening panels, $100,000 limits on physician liability, and a doctor-funded patient catastrophic fund for awards over that amount up to $500,000. In addition, they will seek passage of various tort law changes, including a maximum nine-year statute of limitations for minors (it is currently three years for adults) and a sliding scale of lawyers' contingency fees similar to that in New Jersey.

Many physicians in states that have already passed comprehensive medical malpractice laws, however, are beginning to grumble that nothing seems to have changed—despite their legislative success. "Doctors are disappointed that tort reform didn't result in immediate premium relief," said Ohio State Medical Association executive director Hart F. Page. "I tell them it's like expecting a fever to go down five minutes after giving a patient penicillin."

Still, Page is obviously worried about the law's ultimate effect on the things that count with doctors—availability and price of malpractice insurance. Last year Ohio passed laws that made a provider liable contractually only for written promises, clarified the meaning of "informed consent," and set lawyers' contingency fees at 33⅓%. In addition, the legislature established voluntary binding arbitration, a JUA, and the requirement that malpractice suits be reviewed by the state's medical licensing board. Ohio also has a one-year statute of limitations, about the shortest in the nation.

Even in Indiana, there has been "no appreciable change" in the number or amounts of malpractice suits in the state since July 1, the day the Indiana law went into effect, according to Robert Miller, a vice president of Medical Protective in Fort Wayne, Ind., which now insures about 60% of the state's physicians and probably will pick up most of St. Paul's customers (another 28%) as that firm drops them when policies come up for renewal. The situation in "areas where there was a trend toward high claims continues to deteriorate," Miller said.

The Malpractice Study Commission established by law in Indiana has held several meetings but has not yet proposed further changes in the state's professional liability laws. A medical society spokesman said serious consideration is being given to starting up the self-insurance plan authorized under the 1975 law. And the state insurance commissioner reportedly is reconsidering his opposition to the claims-made policy. It was this opposition that St. Paul says drove it out of the Indiana malpractice insurance market.

Indiana State Medical Association officials, like those in California, Florida, Louisiana, Oregon, and Wisconsin, are anxiously awaiting court judgments on the constitutionality of their "caps" on doctors' liability, which range from maximums of $100,000 to $500,000. Lower courts in two states so far—Idaho and Illinois—have ruled such statutory limits on physician liability to be unconstitutional. In addition, an Illinois circuit court judge recently ruled that the medical review board set up by that state's new malpractice law is unconstitutional. Likewise, a North Carolina superior court judge has ruled unconstitutional his state's reinsurance exchange—a special form of JUA that requires every firm writing property and casualty insurance in North Carolina also to offer physicians' professional liability coverage.

Until the constitutional question of "caps" on doctor liability is settled one way or another, a number of medical societies will not propose liability limits for their 1976 malpractice legislation. In Michigan, for example, a "cap" on doctors' liability was noticeably absent from the medical society's comprehensive package of malpractice legislation—most of which passed the state assembly. Nor will there be such a proposal this year, a medical society spokesman said. "We're waiting to see what's going to happen in Idaho before we try for that," he said. The Idaho Medical Association will appeal to the state's supreme court in an attempt to re-establish its $50,000 limit, according to its new executive director, Don Sower.

The dearth of spectacular improvements in the malpractice situations of states like Indiana and Idaho raises the specter that nothing they can do—nothing at all—can reverse the calamitous situation spreading across the country like a disease. (A spokesman for the California Medical Association describes the prospects for southern California early this year as being "in the nature of a cataclysm.")

Waiting in the wings is the federal government—specifically Sen. Edward M. Kennedy (D-Mass.) with a pocket full of "national" solutions (MWN, May 5, '75, p. 23)—when states try and fail to solve the malpractice crisis themselves. But many physicians consider Senator Kennedy's cures—which would lock them into the PSRO system, among other things—worse than the disease itself. So far, the Ford Administration has held to its original position that the states must first be given the chance to solve their own malpractice problems. In this same spirit, a uniform medical malpractice act is now being put together for all state governments by the National Conference of Commissioners on Uniform State Laws, located in Chicago. But time is clearly running out.

The question remains: If the most comprehensive state laws ultimately fail to have an impact on the availability and price of physicians' professional liability insurance, what good will any kind of state law do, uniform or otherwise? What, then, would be the alternative to one of Senator Kennedy's proposals?

—REGINALD W. RHEIN JR.

File Malpractice

REMARKS BY
ROBERT A. BAILEY
ACTUARY FOR THE CENTRAL OFFICE STAFF
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS

RECEIVED

BEFORE THE
LEADERSHIP CONFERENCE OF THE
AMERICAN MEDICAL ASSOCIATION

Chicago, Illinois
January 24, 1976

I appear before you today as th Casualty Actuary for the National Association of Insurance Commissioners. The National Association of Insurance Commissioners (frequently called the NAIC) was organized in 1871. Its membership consists of the chief insurance regulatory authorities of the 54 states and jurisdictions of the United States. As such it is the oldest voluntary association of state officials. I am the director of its statistical program and the individual in charge of the current NAIC malpractice closed claim statistical study.

Today I will describe the statistical programs being conducted by the NAIC to obtain data concerning the medical malpractice problem, and then I will summarize some of the conclusions obtained from the data compiled so far. The views I express here are my own and do not necessarily represent those of the NAIC.

At the NAIC we are familiar with the legislative medical malpractice reforms sponsored by the AMA which were distributed to you shortly after your meeting here a year ago. We have

been keeping track of all the legislation enacted this year in the various states. It is an impressive record and includes a good number of your proposals in various forms. According to our count, 42 states have enacted legislation during 1975 dealing with medical malpractice. 32 of these states have enacted legislation dealing with the immediate problem of assuring availability of medical malpractice insurance. 33 have enacted legislation aimed at reforming the legal system both substantive and procedural. 32 have enacted legislation which focuses on the health care delivery system. And 32 have authorized further studies of the malpractice problem. This reflects unusually widespread legislative concern and activity. The NAIC and others are publishing periodic summaries of the legislation as it is enacted.

As far as we know, much of the heat generated by the medical malpractice controversy centers on medical malpractice insurance and its cost. Actually, however, such insurance - important though it may be - is really the tail end of the kite. The issue had its origin in legal and medical aspects far beyond the control of the insurance business and those of us who regulate it. Furthermore, many of the difficulties have their genesis in inflation, the magnitude of which is largely influenced by national policy. This is an unbelievably complex subject with boundless ramifications. We see no easy

solution to it. The NAIC has made a pioneering contribution to the search for a solution by making available statistics which have been heretofore lacking. But the statistics have not yet pointed the way to a simple overall solution; on the contrary, they simply emphasize how difficult it will be to find one.

The NAIC is obtaining a report on each insurance claim for medical malpractice that is closed on or after last July 1. We expect to continue this program for at least one year. This study is intended to develop data on the costs and causes of medical malpractice claims which can be used to evaluate legislation already enacted, design new remedial legislation and develop programs aimed at preventing medical injuries. This program is under the immediate direction of the NAIC Subcommittee on Professional Liability Insurance, chaired by Commissioner Rawls of Oregon. We plan to publish four summaries of this data during the year of which the first was published last month. These four summaries are available on a subscription basis. I will discuss some of the data in that summary in a moment.

The NAIC has also initiated another statistical program to obtain data on medical malpractice insurance in the annual and quarterly financial statements of insurance companies. This data will show who is writing malpractice insurance

in each state, how much they are writing and what their profits or losses are in each state. It will show trends in how many claims are occurring and trends in how much each claim costs. Much of this data will be available separately for physicians, hospitals and other miscellaneous categories. This data will begin to become available this year as the annual and quarterly financial statements are filed. It will be summarized in various NAIC publications during the year.

Now let us take a look at some of the data we already have to see what answers it has for our problems. It is evident from this first summary of some 4000 closed claims that there are no easy answers. The data shows that the problem is every bit as complex as we suspected and just as serious as we all knew it was.

We have several reports on how long it takes for a claim to be reported after the incident occurs and then, after it is reported, how long it takes to be settled. It takes an average of about one year for claims to be reported, a little longer for serious claims. This average varies some from state to state. About 86% of the claims are reported within two years, and about 98% within four years. Although shortening the statute of limitations may not have a significant effect on the number of claims reported, it may speed up the reporting in some instances. This may help the insurance companies price the insurance with less uncertainty.

After a claim is reported it takes an average of about two years to settle. This varies by state and by size of claim. Claims still unsettled five years after the date of incident involve 10% of the claims by count and 21% by amount. This long delay from incident to settlement, which averages about three years, makes this kind of insurance one of the most difficult to price accurately in advance. This is a guessing game. So many insurance companies have been burned so badly that many have abandoned the field. Recently prices have risen so rapidly there is the possibility that insurers have overreacted. But no one will know for sure until four or five years from now and by then it will be too late to do anything about it.

In response to the high prices and lack of an adequate market for malpractice insurance, many state medical and hospital associations have formed their own insurance company. Having your own insurance company will enable you to reflect your own costs more directly in the price of your own insurance for better or for worse, whichever it turns out. But it is interesting to note that many of the "Doctors Mutuals" do not want to accept all applicants. This, in effect, says to the public that the medical profession wants to allow some physicians to continue practicing that the profession's own insurers are not willing to insure. In turn, this suggests

that some type of review mechanism as to the quality of care rendered be tied into a mutual insurance program where all physicians that pass the review system would be eligible for the insurance program. Those not eligible for insurance would be barred from practicing. In any event, this is food for thought.

The data shows that 86% of the amounts paid are related to claims where the incident occurred in a hospital but only 32% of the amounts paid are paid by hospitals. This, of course, reflects the fact that most of the physicians who practice in a hospital are not employees of the hospital. As a result most of the claims are paid by the physicians. This data indicates that the Virginia proposal of making hospitals responsible for all incidents occurring in the hospital would shift a substantial portion of the cost from physicians to hospitals and at the same time would place the responsibility for a high proportion of all malpractice incidents in the hands of a third party, the hospital, who has some degree of control over who practices in the hospital and how they practice as well as some control over the safety engineering programs in the hospital, where most injuries occur. Such a proposal may create a substantial financial incentive for the hospital to perform an effective review function regarding those who practice in the hospital.

The summary of claims by specialty of physician shows that orthopedists, obstetricians, gynecologists, cardiologists, plastic surgeons and anesthesiologists generate a relatively high volume of claims. But it also shows that the two categories of physicians that generate the largest number of claims, although a relatively lower frequency per physician, are physicians who perform no surgery and physicians who perform only minor surgery. It is evident that all physicians are exposed to the risk of a collectible malpractice claim. The malpractice problem is not confined to a few small types of practice.

There are about twice as many claims against self employed physicians as against those who are members of a professional corporation or partnership. You can probably judge better than I whether this is close to the comparable proportions of physicians in solo and group practice.

The number of claims against physicians who are board certified are about 1 1/2 times the number against physicians who are not board certified. Inasmuch as the number of physicians who are board certified is only about 1 1/4 times the number who are not, it appears that board certified physicians have a slightly higher claim frequency. This probably reflects a more specialized practice and a greater

number of high risk procedures by board certified physicians. In future reports we plan to analyze board certification according to each specialty.

The summary of claims by country of professional education shows that 12% of the claims are against physicians who received their education in a foreign country. The percentage of physicians with a foreign education is considerably greater than their percentage of claims indicating that physicians with a foreign education have a considerably lower claim frequency. Physicians trained in the Philippines had 2% of the claims. Cuba and India each had 1%. Every other country was less than 1/2 of 1%, including Canada, Mexico and England.

The first report contained approximately 1000 claims for which the following items were coded, using the H-ICDA codes: (1) the diagnosis for which treatment was sought, (2) the procedure that caused the injury, and (3) the injury.

The 992 claims for which the diagnosis was coded were scattered over 461 different diagnoses. Even the most frequent diagnosis, delivery, had only about 4% of the claims. There were only 12 diagnoses that had 10 or more of the claims:

38 Delivery without complication

22 Voluntary sterilization

18 Radiologic examination

17 Fracture of upper end of femur

10 Malignant neoplasm of bronchus and lung

10 Malignant neoplasm of breast

14 Acute myocardial infarction

12 Acute appendicitis without peritonitis

13 Acute appendicitis with peritonitis

10 Fracture of tibia and fibula

13 Single, term, hospital birth

12 Family planning for contraception

The 789 claims for which the procedure causing the injury was coded were scattered over 312 different procedures. The most frequent procedure, hysterectomy, had about 4% of the claims. There were only 15 procedures which had 10 or more claims:

13 Operations on spinal cord structures

14 Appendectomy

22 Laparotomy

32 Abdominal hysterectomy, total

11 Dilation and curettage of uterus

19 Cesarean section

19 Reduction of fracture and dislocation

11 Excision of intervertebral disc

13 Inhalation therapy

26 Transfusion of blood and blood components

13 Cast immobilization

17 Administration of anesthetic gas

15 Administration of unspecified drugs

15 Injection of systemic drug

23 Emergency room visit

The 1172 claims for which the principal injury was coded were scattered over 734 different injuries, only six of which, other than nonspecific codes indicating a diagnostic error, had 10 or more claims. The most frequent injury, accidental puncture or laceration,generated about 3% of the claims.

14 Serum hepatitis

22 Cardiac arrest

25 Laceration of face

37 Accidental puncture or laceration

32 Anaphylactic shock

21 Other serum reaction

I have gone into all of this detail regarding the diagnoses, procedures and injuries involved with malpractice claims to show that the problem is widespread and is not isolated anywhere. It appears to involve the entire spectrum of medical care. This in turn suggests we cannot expect to find some panacea for the malpractice problem.

The average amount of indemnity paid per closed claim, counting each defendant separately, was $6672. If the claims closed without payment are excluded, the average per paid

claim was $17,722. If each injury is counted only once regardless of the number of defendants, the average per paid injury was about $20,000. That was for claims closed in 1975 which were incurred, on the average, about three years earlier. The cost of claims occurring now in 1976, which will be paid, on the average, several years in the future, will undoubtedly be much greater.

The cost of a claim varies, of course, according to the severity of the injury. Our summary of closed claims indicates that injuries classified as "permanent minor" had a cost about equal to the overall average. "Permanent significant" claims cost about twice the average, "permanent major" and "permanent grave" cost about seven times the average. "Death" cases cost about 60% more than the average.

Of the claims for which sufficient information was available to ascertain the type of misadventure involved, actual or alleged, 66% involved misadventures in procedures and 34% involved misadventures in diagnosis. 16% involved misadventures in procedures where the procedure was not adequately indicated, was contra indicated, or there was a better alternative. Most of the misadventures in diagnosis were delay in diagnosis or misdiagnosis of an abnormal condition.

I have attempted to summarize for you the data the NAIC is gathering to help us understand the nature of the medical malpractice problem. Data will continue to be compiled to help us measure the effects of the remedial measures that are adopted. Our current problems are serious and may get worse in the short term. But I am confident that our continued search for better solutions for this complex problem will enable us to deal with it in a manner most satisfactory to all concerned.

1975

STATE LEGISLATIVE ACTIVITY

MEDICAL MALPRACTICE

CATEGORY OF LEGISLATION	NUMBER OF STATES
ALL TYPES OF LEGISLATION	42
AVAILABILITY OF INSURANCE	30
REFORM LEGAL SYSTEM	33
REFORM HEALTH CARE DELIVERY SYSTEM	32
AUTHORIZED FURTHER STUDIES	32

CLAIMS REPORTED

WITHIN 2 YEARS	86%
WITHIN 4 YEARS	98%
AVERAGE TIME	1 YEAR

CLAIMS SETTLED

AVERAGE TIME	2 YEARS FROM REPORT 3 YEARS FROM INCIDENT

CLAIMS UNSETTLED AFTER 5 YEARS

BY COUNT	10%
BY AMOUNT	21%

AMOUNTS PAID

INCIDENT OCCURRING IN HOSPITAL	86%
PAID BY HOSPITALS	32%

COUNTRY OF PROFESSIONAL EDUCATION

U.S.A.	88%
FOREIGN	12%

PHILIPPINES	2%
CUBA	1%
INDIA	1%

DIAGNOSIS FOR WHICH
TREATMENT WAS SOUGHT

CATEGORY OF DIAGNOSIS	NUMBER OF CLAIMS
ALL (461 DIFFERENT DIAGNOSES)	992
DELIVERY WITHOUT COMPLICATION	38
VOLUNTARY STERILIZATION	22
RADIOLOGIC EXAMINATION	18
FRACTURE OF UPPER END OF FEMUR	17
MALIGNANT NEOPLASM OF BRONCHUS AND LUNG	10
MALIGNANT NEOPLASM OF BREAST	10
ACUTE MYOCARDIAL INFARCTION	14
ACUTE APPENDICITIS WITHOUT PERITONITIS	12
ACUTE APPENDICITIS WITH PERITONITIS	13
FRACTURE OF TIBIA AND FIBULA	10
SINGLE, TERM, HOSPITAL BIRTH	13
FAMILY PLANNING FOR CONTRACEPTION	12

PROCEDURE CAUSING THE INJURY

CATEGORY OF PROCEDURES	NUMBER OF CLAIMS
ALL (312 DIFFERENT PROCEDURES)	789
OPERATIONS ON SPINAL CORD STRUCTURES	13
APPENDECTOMY	14
LAPAROTOMY	22
ABDOMINAL HYSTERECTOMY, TOTAL	32
DILATION AND CURETTAGE OF UTERUS	11
CESAREAN SECTION	19
REDUCTION OF FRACTURE AND DISLOCATION	19
EXCISION OF INTERVERTEBRAL DISC	11
INHALATION THERAPY	13
TRANSFUSION OF BLOOD AND BLOOD COMPONENTS	26
CAST IMMOBILIZATION	13
ADMINISTRATION OF ANESTHETIC GAS	17
ADMINISTRATION OF UNSPECIFIED DRUGS	15
INJECTION OF SYSTEMIC DRUG	15
EMERGENCY ROOM VISIT	23

ACTUAL AND ALLEGED INJURIES CAUSED BY MALPRACTICE

CATEGORY OF INJURIES	NUMBER OF CLAIMS
ALL (734 DIFFERENT CATEGORIES)	1172
SERUM HEPATITIS	14
CARDIAC ARREST	22
LACERATION OF FACE	25
ACCIDENTAL PUNCTURE OR LACERATION	37
ANAPHYLACTIC SHOCK	32
OTHER SERUM REACTION	21

AVERAGE AMOUNT OF INDEMNITY

PER CLAIM	$ 6,672
PER PAID CLAIM	$17,722
PER PAID INJURY	$20,000. APPROXIMATELY

SEVERITY OF INJURY	PERCENT OF CLAIMS	PERCENTAGE OF AVERAGE AMOUNT
EMOTIONAL ONLY	10%	8%
TEMPORARY INSIGNIFICANT	12%	10%
TEMPORARY MINOR	29%	29%
TEMPORARY MAJOR	10%	81%
PERMANENT MINOR	10%	101%
PERMANENT SIGNIFICANT	5%	226%
PERMANENT MAJOR	3%	683%
PERMANENT GRAVE	2%	784%
DEATH	19%	163%
ALL	100%	100%

MISADVENTURES IN PROCEDURES	PERCENTAGE OF CLAIMS
NOT ADEQUATELY INDICATED	8%
CONTRA INDICATED	4%
BETTER ALTERNATIVE	4%
DELAYED	6%
IMPROPERLY PERFORMED	39%
NOT PERFORMED	5%
	66%

MISADVENTURES IN DIAGNOSIS	PERCENTAGE OF CLAIMS
DELAY	13%
MISDIAGNOSIS OF ABNORMAL CONDITION	16%
NO ABNORMAL CONDITION	5%
	34%

STATE OF ALASKA
THE LEGISLATURE
LEGISLATIVE AFFAIRS AGENCY

POUCH Y - STATE CAPITOL
JUNEAU, ALASKA 99801

M E M O R A N D U M December 8, 1975

SUBJECT: Governor's Medical Malpractice Commission
Proposed Legislation

TO: Rep. Mike Beirne

FROM: Anne Carpeneti

Here follows a summary and critique of the bills proposed by the Governor's Commission.

SUMMARY OF BILL A

* Section 1. Requires the Division of Occupational Licensing to provide investigative staff for health care licensing boards. -Sec. 13.

* Sec. 2/ Requires that active, licensed chiropractors, dental hygienists, dentists, physicians, nurses, dispensing opticians, optometrists, pharmacists, physical therapists, and psychologists be insured by the Health Care Provider's Indemnity Corporation or another insurer for at least $200,000 per occurrence and $600,000 aggregate per year; allows the licensing board for these health care providers to limit the practice, censure, or require continuing education for licensees.

* Sec. 14. Statement of purpose.

* Sec. 15. Section 15 provides expert advisory panels for malpractice causes of action. Each panel consists of three licensed health care providers in the state. If the sole defendant is a physician, the panel consists of three physicians; other defendants have representatives in their field or specialty on the panel. The selection process for the panel is somewhat similar to the selection of a jury. The panel may compel attendance of witnesses, may compel delivery of medical records, and may examine parties orally and physically. The panel must submit a report to the court within 30 days of being appointed which answers, where possible, questions submitted to it by the parties in addition to the following questions:

(1) Was the claimant adversely affected by the medical services? If so, how?

(2) What was the adverse affect?

(3) What is the prognosis?

(4) How did the medical services alter the natural course of the pre-existing disorder for which the services were originally rendered?

(5) How did the medical condition existing after performance of the medical services differ from the medical condition which might otherwise have been expected?

If the answers to the above questions are not properly the subject of expert opinion, the panel will so state. The report shall also include a record of all evidence considered by the panel. Dissenting reports may be submitted by panel members. No discovery may be taken until the report is complete, absent special circumstances. The report is admissible in the trial of the cause of action, subject to the court's discretion in excluding evidence. The report may be refuted by additional expert testimony, and members of the panel may be cross-examined. Panel members receive travel and per diem from the state.

* Sec. 16. Changes the burden of proof in medical malpractice cases to that of due care under the circumstances in the defendant's field, instead of in the community where the defendant practices, and provides that in cases filed three or more years after the act complained of, the plaintiff must prove negligence by clear and convincing evidence. (The present burden is that of showing negligence by a preponderance of the evidence in all cases.)

* Sec. 17. Provides that damages awarded to the plaintiff in all cases filed three years or more after the cause arose be paid out of the Health Care Providers Late Claims Fund (hereafter Late Claims Fund), which has no right of subrogation against the defendant; provides that the verdict be made according to the category of loss and that future losses be paid periodically rather than in a lump sum; and that damages may not be made for expenses already paid for by collateral sources unless the source is a federal program requiring subrogation.

* Sec. 18. A housekeeping section.

* Sec. 19. Provides that no cause of action against a provider may be based on an oral promise of cure; that a health care provider is not liable for failure to obtain consent of the patient for a procedure unless the plaintiff proves that a reasonable

person would not have consented to the procedure if informed and that the case involved non-emergency or diagnostic procedures; and provides defenses to an otherwise valid claim based on informed consent, for example, if the physician believed that disclosure would adversely affect the patient's condition.

* Sec. 20. Extends the "good samaritan rule" to hospital emergency situations.

* Sec. 21. Requires every licensed hospital to be insured against malpractice by the Indemnity Corporation for at least $200,000 per occurrence and $1,000,000 per year aggregate for every 50 beds.

* Sec. 22. Establishes guidelines for treatment of information presented to review organizations in hospitals; for example, limits liability for defamation of persons furnishing information to review organizations and members and staff of the review organizations to cases involving known falsehood or malice.

* Sec. 23. Section 23 adds a new chapter to Title 21 which creates an Indemnity Corporation, a backup Joint Underwriting Association (JUA), and a Late Claims Fund.

The Indemnity Corporation acts through a board of governors appointed by the governor and consisting of representatives of professional organizations and the insurance field; board members serve three year terms. The board prepares a corporation plan of operation, subject to the approval of the director of insurance, for provision of fair and reasonable malpractice insurance for health care providers in the state. The corporation would have the power to issue policies of insurance, collect premiums, procure reinsurance, hire employees, and perform other functions necessary to operation. A premium tax of 1-1/2 per cent of the total direct premiums collected is levied on the corporation. The corporation is required to insure all licensed providers who pay premiums.

A backup JUA is provided in case the corporation is unable to obtain reasonable insurance for providers in the state. Disability, property, and casualty insurers in the state would be required to participate as a condition of doing business in the state. The JUA would be governed by the corporation's board and operate according to a plan of operation developed by the board, subject to the approval of the director of insurance.

The late claims fund is created to pay all claims based on medical malpractice filed three years or more from the date of occurrence. The director of insurance defends all claims made on the fund, pays claims won against it, sue or be sued in the name of the fund, borrow money for the fund, and other things necessary for the fund. The fund is to be built from annual assessments against health care providers. If the board of the corporation believes that the assessment is not affordable, it shall notify

the legislature, and the legislature may contribute if it chooses. If the legislature does not contribute the assessment remains final. The state is liable for claims against the fund which the fund cannot pay.

SUMMARY OF BILL B

This bill presumes the passage of a constitutional amendment of Article I, Sec. 16 of the Alaska constitution to exempt medical malpractice cases from that section's guarantee of the right to a jury trial in civil cases where the amount in controversy exceeds $250. It establishes a Medical Injury Adjudication Board with 12 members serving five year terms. Three of the members must be physicians, and the remaining may be neither health care providers, attorneys, or persons from the insurance industry. The board hears cases in committees of four members (one of which is a physician). The board is aided by an expert advisory panel, which has the same powers and duties as the advisory panel of Bill A. All medical malpractice causes of action must be filed with the board; dollar amounts for damages may not be specified in the claim. Damages are to be awarded by category of loss and in installments for future damages if the board so decides. Judgments by the board may be appealed to the Supreme Court of Alaska.

JOINT RESOLUTION

The proposed joint resolution exempts medical malpractice cases from Article 1, Section 16 of the Alaska constitution. That section guarantees the right of a jury trial in civil cases where the amount in controversy exceeds $250.

CHANGE IN RULES OF CIVIL PROCEDURE

This proposes a new rule of procedure for appointing an expert advisory panel in medical malpractice cases. It is essentially the same as the provisions in Bill A regarding the expert advisory panel.

COMMENTS ON BILL A

The first issue is whether this approach will solve the physicians' problems in regard to the cost and availability of medical malpractice insurance. One of the more disturbing facts coming to light during the past year is that somewhere between 15 - 20% of the medical malpractice premium dollar goes to injured patients. By adding an additional layer, an expert advisory panel, you may only increase the administrative cost as compared to the payout to plaintiffs recovering verdicts. The rationale, of course, is that if the panel advises that the defendant was not negligent, plaintiffs

will be encouraged to drop the suit or settle for a smaller amount than he would otherwise demand. It assumes that the panel will weed out nuisance suits and lower the legal expenses insurers incur.

The second question is of fairness. Can a panel of health care providers (mainly physicians) be truly unbiased? Physicians have been traditionally unwilling to speak out against their colleagues. Findings of a panel which is supposed to be neutral would probably have a great deal of influence over a factfinder, and the fairness to plaintiffs ought to be considered.

The rationale of requiring the same minimum levels of insurance for all providers (except hospitals) is not clear. It is reasonably certain that a surgeon has a much higher potential liability than, for example, a nurse.

It is wise to allow licensing boards more flexibility in regulating its licensees. It is not clear, however, that requiring that the Division of Occupational Licensing ~~be~~ provide investigative staff to the licensing boards gives the boards sufficient resources to thoroughly regulate its licensees.

The fairness of changing the plaintiff's burden of proof to "clear and convincing" in cases filed three years or more after the occurrence ought to be explored. This is a significantly more difficult burden to meet.

The approach to informed consent in the bill is, I believe, weak. The circumstances where a provider need not explain the risks and alternatives to the patient are very broad.

The administration of the Late Claims Fund appears to be rather awkward. If it is determined that the assessment to providers is unaffordable an appropriation from the legislature is requested; if the legislature does not respond, the "unaffordable" assessment is collected anyway. In addition, the bill provides that any excess liability over assets is chargeable to the state; thus, there are no compelling reasons for the fund to be viable anyway.

COMMENTS ON BILL B

The major issue which this bill raises is the wisdom and constitutionality of abolishing the right to a jury trial in medical malpractice cases. The fairness of this approach should be addressed as well as due process and equal protection issues.

The composition of the board also gives rise to questions. Is it reasonable to require that three members be physicians, while attorneys and insurance people are excluded?

Comments on the resolution and the change in the Rules of Court are included in the comments on Bills A and B.

AC:cb

Supplement to the Report to the Legislature of the State of Alaska on Medical Malpractice Proposals

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(Initial Report Dated December 4, 1975 and presented in Juneau, Alaska on December 9 and in Anchorage on December 10, 1975)

February 20, 1976

1. On December 9, 1975, I met in Juneau, Alaska with a group that included Representative Mike Miller, Vice Chairman of the Legislative Council, Senator John Huber, Representative Fred Brown, Representative Larry T. Davis and staff members.

2. The next day I had a series of meetings with various members of the legislature, including Senator Chancy Croft, Senator Jalmar M. Kertulla, Senator Patrick Rodey, Representative Fred Brown, Representative Larry Davis, Representative Samuel R. Cotten, Representative Kathryn Ostrowsky, Representative Charles Parr, and staff members. In addition I talked to members of the Judiciary Committee before their meeting on Rent Control. Those attending, in addition to members of the legislature, included some members of the Governor's Commission on Medical Malpractice and other members of the public.

3. In the course of these meetings, and other informal discussions with members of the legislature, I made a series of comments and recommendations, which do not appear in my report. Some of these additional remarks are briefly summarized here to serve as a supplement to my initial report dated December 4, 1975. I have also included my response to several questions raised by members of the legislature.

4. The law of Alaska should be clarified so any advance payments on malpractice or other claims would not be considered an admission of liability and would be deducted from any final judgment.

Indiana, Louisiana, Nebraska, Nevada and Wisconsin have passed laws relating to this matter. Nebraska (Legislative Bill 560, passed in 1975) provides any advance payment will not be an admission of liability, and further that: "In the event of a trial involving such a claim, the fact that such payments have been made shall not be admissible in evidence or brought to the attention of the jury, and the matter of any credit to be deducted from a judgment shall be determined by a court in a separate hearing or upon the stipulation of the parties."

This should encourage early payment on claims, early settlements, and attempts to minimize damages by early medical treatment. (A similar approach has been suggested in the report on no-fault as to auto liability claims.)

5. Mandatory arbitration should be considered to provide a more economical determination of cases and a sweeping out of some of the flimsy claims. This would not impair the right to trial by jury as there would be a right of appeal de novo to the courts.

6. The Governor's Commission recommended legislation (p.15, sec.9.55.540(c)) subjecting claims more than three years old to a higher standard of proof than would be otherwise imposed on civil claims. This appears to be an unfair and unreasonable requirement, and any attempt to apply such a standard would probably create more confusion and problems than it would dispel.

7. Senator Huber asked me to comment on a provision in the crime compensation act making attorney's fees an addition to any award. This is certainly a sound provision and will help assure that any damages assessed will not be diverted immediately from the purposes for which they are awarded.

Whether this kind of provision is essential depends on the kind of compensation program being considered. For example, in workmen's compensation, the law may be designed to make sure the worker can collect without the need for a lawyer. If this is the case and if the assumption is sound, paying for all attorney fees may simply bring in lawyers needlessly and increase costs.

The National Commission on State Workmen's Compensation Laws had this to say on attorney fees: "An additional question is whether the employee or the employer should pay the employee's attorney's fee. With the adoption of our recommendations for improvements in the delivery system and the adequacy of benefits, it is not unreasonable to hold the employee primarily responsible for any attorney's fees that he incurs. However, States should consider the shifting of these fees to the employer as a form of penalty in those cases in which the employer or his insurer has acted in an unjustified manner."

This view of the National Commission is not entirely logical. Even if benefits are adequate, they will be rendered inadequate by deduction of attorney's fees.

The National Commission of Malpractice also considered the question of attorney's fees. It recommended regulating the contingent legal fee by establishing a scale in which the fee decreases as the recovery amount increases (a similar recommendation appears in my earlier report on malpractice).

Here, too, recoveries, if properly determined, will be rendered inadequate by deduction of attorney's fees. However, some believe juries tend to pad awards to cover legal expenses.

Ideally, recovery should include actual damages as well as expenses of litigation. To do so would increase the cost of malpractice insurance. It would also raise the question of charging the plaintiff with the defendant's attorney's fees in cases which the defendant won. All of this would introduce further uncertainties into the litigation process, and perhaps make the right to a day in court even more difficult to obtain.

Although the addition of attorney's fees in another context may be entirely appropriate, it is not clear that in the malpractice field this would be a wise practical measure.

There would be general agreement that requiring the payment of attorney's fees in cases in which there is unreasonable failure to pay benefits (or other unjustified action) is an appropriate measure. This kind of provision can be found in workmen's compensation laws. There, it has practical value, as most cases are clear cut with no room for argument, but in malpractice cases few claims are so clear cut, so the provision would have little practical value.

8. Representative Parr asked me to comment on how the malpractice system could be changed to make it possible for a small but meritorious claim to be collected. In small malpractice claims, it may not pay an attorney to handle the matter on a contingent fee basis. The National Commission on Medical Malpractice found cases in which claimants had to abandon a case which might be worth $10,000 because even such a meritorious case did not offer adequate incentive to an attorney working on a contingent fee basis (See p. 35 of National Malpractice Commission Report).

The only remedy the National Commission could suggest is to establish "public legal assistance mechanisms" or to expand those that already exist "to assure adequate legal representation to persons with small malpractice claims."

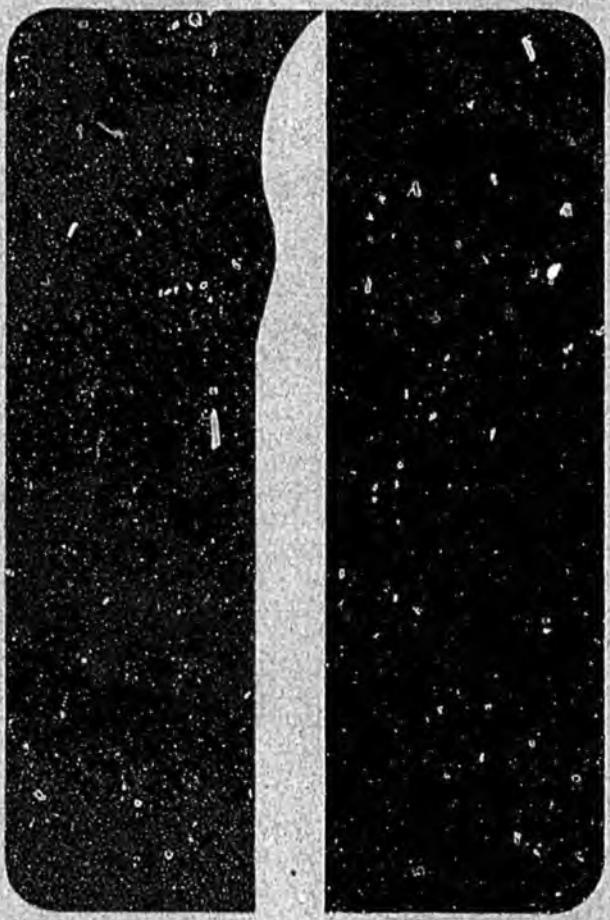
The ready availability of arbitration may somewhat ease the problem. Another suggestion is to establish small claims courts presided over by those technically proficient in the area of medical legal malpractice. In other words, this would be a special small claims court for malpractice claims.

There is probably no good answer for this problem at the present time. Perhaps at one point no-fault malpractice compensation systems will become practical, and enable small meritorious malpractice claims to be adequately compensated.

A shopper's guide to surgery

Fourteen Rules On How To Avoid Unnecessary Surgery

By
HERBERT S. DENENBERG
Pennsylvania Insurance Commissioner



FOREWARD

"Free choice of physician" is frequently invoked by medical spokesmen as the keystone of the U.S. Health System. If this privilege is used wisely, a powerful force could shape an effective, humane and responsive health care system.

"Free choice of physician" is only a hollow slogan for a public unprepared to make an informed and intelligent choice. The ability of the public to make an informed choice of a medical professional has diminished as medicine has become more complex and impersonal. Dissatisfaction and confusion accompany an individual's inability to choose wisely.

Experienced physicians understand that successful health care requires the active cooperation of the patient. The process should start when the patient selects his physician. If a patient enters the system confused, dissatisfied and passive, he often retains these attitudes throughout his treatment.

Commissioner Denenberg's suggestions are practical and easily understood. He has provided a clear Guide to high quality surgical care which encourages patients to become active participants in their treatments.

Leonard Bachman, M.D.
Governor's Health Services Director

PREFACE

Too many people (some say up to two million a year or more in the United States) are subjecting themselves to unnecessary surgery. They often do so without adequate investigation or consideration.

Dr. Paul R. Hawley, a famous medical authority and surgeon, has said: "I shall never cease to be astonished at the number of people who would not invest a penny in any enterprise without full assurance of its safety, yet who will hop on the operating table and permit anyone to cut into their bellies."

Unnecessary surgery takes a needless toll of human lives and generates suffering, disability and expense.

Many studies have documented our national scandel of unnecessary surgery. One of the most noteworthy of these studies was conducted in 1962 to 1964 by the Columbia University School of Public Health and Administrative Medicine. The group surveyed various types of surgery. It found, for example, that of 60 hysterectomies, "1/3 of the patients were operated on unnecessarily and that question could be raised on the advisability of the operation in another 10 percent." Of 13 caesarian sections (delivery of a baby by means of an abdominal operation), there were serious questions about the necessity of surgery in seven cases. There is every reason to believe that the conclusions of the Columbia study are still valid.

A Ralph Nader group in 1971 as well as other independent investigations have reached the same conclusion. Dr. Charles E. Lewis, a Harvard specialist in community health, concluded a 1969 study of the

incidence of surgery with this comment: "The results presented might be interpreted as supporting a medical variation of Parkinson's law: patient admissions for surgery expand to fill beds, operating suites and surgeon's time." And there is an abundance of professional opinion that unnecessary surgery is widespread. Dr. John Knowles, now President of the Rockefeller Foundation in 1972, warned that "incredible amounts of unnecessary surgery are going on"(Baltimore Sun, May 29, 1972, page 4).

This short "Shopper's Guide to Surgery" is intended to give the public some basic rules on how to avoid unnecessary surgery. It is also intended to give the consumer the kind of information he needs to help hold down the cost of health care and to better utilize the health delivery system.

This "Guide" is the fourth in our series; the first was the "Shopper's Guide to Hospitals in the Philadelphia Area"; the second was the "Shopper's Guide to Auto Insurance"; and the third was the "Shopper's Guide to Life Insurance." We also have other "Guides" in preparation, including a "Shopper's Guide to Health Insurance" and a "Shopper's Guide to Homeowners Insurance."

We are also enlisting the aid of others in the preparation of needed consumer Guides. In November of 1971, we ordered Blue Cross of Western Pennsylvania to publish a "Shopper's Guide to Hospitals" for the 29 county area of Pennsylvania it serves. It published such a Guide in June of 1972, entitled "Directory of Hospital Costs and Services in Western Pennsylvania."

Ralph Nader, the leading consumer advocate, has called on other Insurance Commissioners to follow our lead and prepare Guides of their own. We think that's an excellent suggestion. We also think it would be sound for consumer and industry groups to start following suit. It's about time the consumer gets the facts. It's about time we make our free enterprise system of competition work like it's supposed to. It's about time we give the public the facts. We think these "Shopper's Guides" are a step in the right direction.

We know that an informed public will be in a better position to make decisions regarding its own health and welfare. We believe that one of the tasks of government is to inform the public. An informed public will help to prevent abuses that now plague the consumer. These informational Guides, therefore, have an important place in the regulatory processes of government.

Many people contributed suggestions on various drafts of this Guide, most of whom preferred and even demanded that we keep their contributions anonymous. Special thanks are due to Dr. Leonard Bachman, The Governor's Health Services Director, an internationally recognized anesthesiologist; James Mead, Medical Economist of the Pennsylvania Insurance Department; and Rodney F. Pyfer, my Special Assistant.

As future editions of this "Guide" are contemplated, we would greatly appreciate receiving suggestions for improving it.

Herbert S. Denenberg
Pennsylvania Insurance Commissioner

July, 1972

A SHOPPER'S GUIDE TO SURGERY

Some authorities estimate there are as many as 2,000,000 unnecessary surgical operations in the United States each year. How to decide if the surgery you've been asked to undergo fits the category of the 2,000,000 unnecessary operations or the 10,000,000 necessary ones is the purpose of this "Guide."

Don't assume you can place blind trust in our system of medical care. Ralph Nader has pointed out: "Conditions of medical care are often criminally negligent especially for the poor and even at times for the relatively affluent. The endless reports of such conditions by physicians, government investigations and other reliable inquiries and testimony present macabre scenes so repeatedly that they invoke resigned or indifferent responses. The rocketing cost of health care with the advent of socialized payment of physicians' bills through Medicare has not improved the quality of care, but it has enriched the medical profession to an unprecedented degree."

You are placing undue trust in our medical care system if you assume one doctor is as good as another, or that any doctor can provide you with the quality medical care you need. Many doctors, some 15,000 nationally, are licensed but unfit to practice medicine according to conservative estimates, as reported in a 1970 book by Howard R. and Martha E. Lewis called The Medical Offenders. Many doctors may be qualified to render medical care, but may be totally unqualified to perform surgery.

This Guide should help you find a qualified surgeon when you need one. It should also enable you to take other needed steps to avoid unnecessary surgery.

You can't diagnose your own case, but there are some simple rules you can apply to make sure that you really need the surgery that might be prescribed.

Rule 1

Don't go directly to a surgeon for medical treatment. If at all possible, start out by going to a general practitioner or internist. Go to your regular family doctor – a general practitioner or internist – for any initial diagnosis or treatment. Unfortunately, there is a shortage of general practitioners and a surplus of surgeons.

You will also need a general practitioner or internist to treat you after the surgery and to work with your surgeon in providing care both before and after surgery. Everyone should have a family doctor, who is a general practitioner or internist, and you should get one before you're sick. Don't wait until you urgently need one. Select one so he'll be available the minute he's needed. Also, you want him to have time to know you and learn your medical history. Develop a good relationship with a family doctor.

He will then be able to provide you with better care and he'll be more likely to save you from unnecessary surgery.

Most surgeons are competent, conscientious, careful and conservative, as are most other physicians. Some are narrowly trained and tend to do what they are trained to do – operate. A small minority are knife-happy, incompetent and greedy. And there is a tendency for surgeon's to do their thing – which is to perform surgery.

Even in the case of a superb surgeon, a general practitioner or internist can often serve as a countervailing force on any tendency of a surgeon to place too much faith in surgery.

This tendency of medical men (such as general practitioners and internists) to be more conservative than surgeons is documented in Dr. William A. Nolen's best seller, The Making of A Surgeon:

Kevin Jonas (a surgeon) was, naturally, eager to do some heart cases. He would gladly have paid a thousand dollars apiece for potential patients even if he'd have had to steal to get the money, but of course there weren't any for sale. He had to depend on the medical men and they weren't eager to have their patients operated upon. Internists don't take kindly to new surgical procedures; they're from Missouri when it comes to surgical pioneering – as, I suppose, they should be.

Christian Barnard, the famed heart transplanter, in his autobiography, relates how eager he was to find a patient for a heart transplant. "Maybe we were too anxious," he writes. He catalogues his considerable discomfort while eagerly awaiting the first heart transplant operation:

All through the last two weeks of October I kept after Professor Schrire – plaguing him day and night.

The delay and subsequent anxiety caused an alarming flare-up in my arthritis. Both hands and feet began to swell and with such pain I feared it would prevent me from operating when Professor Schrire finally decided to release a patient.

There is some tendency for too much surgery when there are too many surgeons around. It is no mere coincidence that in proportion to population, U.S. surgeons not only are twice as numerous as Engl. surgeons, but also perform twice as many operations.

An authoritative study in 1970 by Dr. John P. Bunker concluded that there is a disproportionately large number of surgeons in the United States and this may lead to some unnecessary surgery. An editorial published in the June, 1972 issue of the Archives of Surgery, a publication of the American Medical Association, confirmed that we have a surplus of surgeons.

Rule 2

Make sure any surgeon that is to perform surgery on you is Board certified. This means his competence as a surgeon has been certified by one of the American Specialty Boards, after a vigorous oral, written and clinical examination. There are about 51,000 surgeons who are Board certified.

One authority, Dr. Robert E. Rothenberg, a well known surgeon, in his book Understanding Surgery, has concluded: "It is safe to say that an American Specialty Board diploma in a doctor's office is almost a guarantee of his efficiency." For some reason, Dr. Rothenberg said nothing of a guarantee of conscience or character. His statement may be too sweeping an endorsement, but a Board certified surgeon is still a sound minimum qualification. It is one important test of a surgeon's ability.

Osteopathic surgeons may be accredited by the American Specialty Board in some states or by their own

American Osteopathic Board of Surgery.

There are competent surgeons who are not Board certified. If you want to use them, you should be careful to check them out all the more carefully by the other rules suggested here.

In some rural areas, Board certified surgeons may not be available. Under these circumstances, the patient may have to travel to a larger city if he cannot otherwise assure himself of the competency of those surgeons available locally.

You can find out for sure if a surgeon is Board certified by calling your local county medical society or using the Directory of Medical Specialists available in most good public libraries.

It pays to look for a competent surgeon. Some reliable experts, including Dr. Paul R. Hawley, have claimed that one-half of the surgical operations in the U.S. are performed by surgeons who are inadequately trained to undertake such surgery. In June of 1972, Dr. Eric W. Fonkalsrud of the editorial board of the American Medical Association's Archives of Surgery, said that about half of the operations in the country are being performed by doctors who are not Board certified surgeons.

One expert, Dr. Harold T. Hyman, in a widely used medical reference book, suggests that the patient not only check out the surgeon but also the anesthesiologist. Others would rely on the surgeon to see that a qualified anesthesiologist is selected for the surgery.

Rule 3

Make sure the surgeon you are to use is a Fellow of the American College of Surgeons (F.A.C.S.). There are about 25,000 surgeons who are designated Fellows. The American College of Surgeons has membership qualifications that keep out the less competent sur-

geons, and the College also stresses programs of continuing education.

This is not an infallible rule, of course, but it is one that is well worth applying in selecting any surgeon.

You can check as to whether any surgeon is a Fellow of the American College of Surgeons in the same fashion as you check to see if he is Board-certified – consult the Directory of Medical Specialists or call your local county medical society. You can also write directly to the American College of Surgeons, 55 East Erie Street, Chicago, Illinois 60611.

The equivalent organization for Osteopaths is the American College of Osteopathic Surgeons located at 1550 South Dixie Highway, Suite 216, Coral Cables, Florida 33146.

Rule 4

Even if your family doctor and surgeon agree that surgery is necessary, consider getting an independent consultation or opinion before subjecting yourself to surgery.

Consultations, according to some studies, reduce operations by as much as 20 to 60 percent. You may be in that 20 to 60 percent. And you have a right to seek consultation.

As one expert, writing under the pseudonym of Dr. Lawrence P. Williams, says in a book entitled How to Avoid Unnecessary Surgery:

The old saying, two heads are better than one, is as true in medicine as anywhere else – possibly even more so, for conscientious doctors have found out that in order to present a problem case to another doctor, they must first review and organize the facts of the case. This in itself often makes the problem

clearer. A second independent surgeon, moreover, may consider certain aspects of the condition quite differently, throwing a new light on the problem. The chance that other factors pertaining to the surgery will be brought out is greater with a consultation.

The second doctor must be truly independent. He should not be part of a 'you-scratch-my-back-I'll-scratch-your-back' arrangement. The second surgeon should be told his opinion is being sought but he will not do the surgery if it is necessary. This removes any financial incentive for him to suggest surgery.

You may want to select the second surgeon on your own, or perhaps get recommendations from your family doctor or surgeon.

When a consultation is to be rendered, the first surgeon ordinarily briefs the second one on the case and his tentative diagnosis and recommendation.

Some would prefer a totally independent opinion rather than an independent consultation, with the second surgeon working on his own and being unaware of the conclusions of the first surgeon. This may remove any tendency to be too quick about going down the wrong path with the first surgeon.

One well-known surgeon suggested that the best way to avoid unnecessary surgery is to get three independent opinions without advising any of the three surgeons involved about the conclusions of the other two.

How many consultations and opinions you should have depends on the facts and circumstances of each case. The need for additional consultations and opinions is a matter which you can discuss with your own doctor and surgeon. In some clear cut cases (pardon this figure of speech), no consultation will be necessary at all. And of course, there may be need for emergency surgery – as, for example, after an auto accident or in the event of a ruptured

appendix – when there may not be sufficient time to follow the rules suggested here.

If a doctor refuses to seek consultation upon request, he is violating the ethical rules of the medical profession. For example, Section 8 of the American Medical Association Principles of Medical Ethics states:

A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical care may be enhanced thereby.

Look out for a doctor or surgeon who is afraid of consultation or becomes angry or disturbed at the prospect of consultation. Drop a doctor or surgeon who can't accept another expert's consultation graciously. As between your doctor's or surgeon's ego and your health, opt for the latter.

If a doctor improperly refuses consultation, you can report his refusal to the county medical society for possible disciplinary action, as well as to Vincent J. Fumo, Acting Commissioner of the Bureau of Professional and Occupational Affairs, 279 Boas Street, Harrisburg, Pennsylvania 17120 (Phone 717/787-2100).

Rule 5

Make sure any surgery is performed in an accredited hospital and, if possible, select a hospital that gives staff privileges (i.e., the right to practice in the hospital) to both your doctor and surgeon. The Joint Commission on Accreditation of Hospitals (J.C.A.H.) certifies that institutions it accredits meet certain minimum requirements designed to assure quality patient care. The standards of the J.C.A.H. are not notably high but they do disqualify the least adequate hospitals and the out-and-out "butcher shops."

Osteopathic hospitals may be accredited by their own

group — the American Osteopathic Association or by the J.C.A.H.

About a fourth of the nation's hospitals are not accredited by the J.C.A.H. or the American Osteopathic Association, but almost all of the better hospitals are. There are about 1,600 unaccredited institutions out of a total of about 7,000 short-term hospitals.

The address of the Joint Commission on Accreditation of Hospitals is 645 North Michigan Avenue, Chicago, Illinois 60611. The address of the American Osteopathic Association is 212 East Ohio Street, Chicago, Illinois 60611.

Another method of assuring quality hospital and surgical care is to make sure the hospital you go to is affiliated with a medical school, and your doctor and surgeon are on the staff of that hospital. Medical school hospitals and their affiliates have a reputation for excellence, and for keeping their medical staffs on the ball.

Rule 6

Don't push a doctor to perform surgery on you. If you insist on surgery, even if it is unnecessary, you are likely to find a surgeon willing to perform it.

There are "overtreaters" who are willing to perform unnecessary surgery, so don't ask for trouble.

As Howard R. and Martha E. Lewis note in their book, The Medical Offenders:

The patients whom overtreaters sell most successfully are neurotic women. A gynecologist new to this country observed: 'In Europe it is all the doctor can do to persuade a woman to have a needed operation. In America it is difficult to dissuade her from having an unnecessary one."

Some women have had six, nine, or 16 major operations in search of relief from their anxiety, malaise, and all-around misery of emotional immaturity.

One doctor has suggested that females are subjected to unnecessary surgery more often than males because of the male dominance of the medical profession. Dr. Francis S. Norris, a surgical pathologist, substantiates this point of view by citing a 1969 Surgeons' Cancer Conference at which it was agreed that surgeons think twice about orchidectomy (surgical removal of a testicle), but rarely hesitate to remove an ovary.

Occasionally a surgeon is overheard to say: "Surgery was unnecessary, but if I didn't do it, someone else would. And at least I did a good job." Don't be so eager for surgery that you prescribe your own unnecessary operation.

Rule 7

Make sure your doctor and surgeon explain both the alternatives to surgery and the possible benefits and complications of surgery.

Any doctor or surgeon should do so and you'll be able to make a more intelligent decision on surgery when you have the facts. As a matter of fact, a doctor that fails to disclose the risks of surgery may open himself up to a malpractice suit. Under the legal doctrine of informed consent, a patient who has not been fairly advised about the risks of surgery has not legally consented to it. He may, therefore, sue any doctor for malpractice who operates on him without fairly disclosing the risks incurred.

All kinds of possible complications may arise from surgery. One expert, Dr. Robert E. Rothenberg, in his book Understanding Surgery, lists five complications:

(1) Pneumonia, once feared, now largely controllable by antibiotics.
(2) Embolism (blood clot).
(3) Postoperative shock.
(4) Wound infections.
(5) Postoperative hemmorhage and wound rupture.

Another serious complication that should be mentioned is cardiac arrest.

The risks of surgery depend on many factors such as age, physical condition, and the nature of the operation to be performed. Such risks are always there and you're entitled to know precisely what they are. Despite all the advances in surgery, one out of every 650 will not come through surgery alive, according to Dr. Rothenberg. That's an average figure, so the expected mortality for any given operation may be much lower or higher.

It is true that some minor procedures involve only slight and almost negligible risk. The uncomplicated removal of a wart without the need for general anesthesia is a good example. If general anesthesia, which involves loss of consciousness, must be used, there is always significant risk. Death and complications from anesthesia are among the most serious risks arising from surgery. Any time general anesthesia is to be used, even an operation that merely involves a surface procedure without cutting into a body cavity, there is a significant risk.

As general anesthesia involves significant risk, it is preferable to have it administered by a physician anesthesiologist who is a specialist, or under his supervision by a certified, trained nurse anesthetist. It is a good idea to be sure the hospital you go to uses a physician anesthesiologist.

Perhaps the best definition of major surgery that puts the risk involved in true perspective is the one that goes like this: If it involves you, it may be minor surgery. If it involves me, it's major surgery.

You should also know what the alternatives to surgery are, such as diet in the case of a peptic ulcer. Surgery is typically a last resort, and you should be as sure as you can that you've explored all treatment short of surgery. Needless to say, you should know the benefits of the proposed surgery. You can hardly judge the risk or even the need for surgery without a clear picture of its likely benefits. Of course, if it is clear that surgery is needed, it should not be delayed to the point where further harm may result.

Rule 8

Frankly discuss the fee for surgery with your doctor. You should know what the surgery is going to cost. Furthermore, most surgeons prefer that the patient understand the cost of surgery in advance. So, forget all about the mistaken notion that it's somewhat improper to inquire about the cost of surgery.

Any surgeon worth his scalpel will gladly discuss fees. If he is not willing to do so, then he doesn't know much about his obligation to the patient and the patient's right to know. Under Phase II of the Federal Wage-Price Stabilization Program, every doctor must post a notice that a record of all his fees is available on demand.

Under Pennsylvania Blue Shield Plans A and B, if your income is under certain specified amounts, the surgeon must accept the fee scheduled in your policy as full payment. If your income is above these limits, the surgeon may charge more than the scheduled amount. (The income limits for Plan A are $2,500 for an individual and $4,000 for a family. Under Plan B, the income limits are $4,000 and $6,000 respectively.)

Be sure you know all costs involved – the surgeon's fees, any fees for his assistant, the anesthesiologist's fees, those of the hospital, special nursing care, your own physician's fees, and any other costs.

This discussion of fees will have several important incidental advantages. It gives you a better idea of the nature of the surgery.

It also may suggest improper arrangements between the surgeon and others. If the assistant's fee is much beyond 20 percent of the surgeon's fee, that may suggest fee-splitting. For example, if the assistant is also a referring doctor, a high assistant's fee may suggest "fee-splitting," a form of unethical kickback to the doctor from the surgeon. Don't put yourself in the hands of a surgeon or doctor that engages in such unethical activity. So, politely question any excessive fees to the surgeon's assistant if fee-splitting is suggested. According to the Lewis' book, The Medical Offenders, fee-splitting is especially widespread in Pennsylvania.

Rule 9

Check the surgeon out with those who know him or have used him. This includes other patients as well as associates of the surgeon.

You might want to check on his background in the Directory of Medical Specialists. What school did he go to? Where did he take his residency? How long has he practiced, etc?

One good way to find the best surgeon is to find out who doctors use when they need surgery for themselves or their families. The greatest compliment to a surgeon is when he is used by a doctor or his family.

Check the surgeon out yourself. You've got to have confidence in him. You don't have to like him, but you should have confidence in him – or find another surgeon.

Rule 10

Make sure the surgeon knows and is willing to work with your general practitioner or internist. To assure

complete, continuous and quality care, close coopera-tion between the surgeon and your doctor is vital.

If they can't work as a team, you may be the loser.

Rule 11

Consider a surgeon who is part of a group practice, and preferably a group that includes internists, surgeons and other specialists. This involves doctors who work together on all their cases, and freely consult and communicate with each other. With a group practice, you are more likely to have a doctor available at all times who is familiar with your case and you have the built-in benefits of consultation.

Some patients are critical of group practice, however, if they get a feeling that they are being passed from one doctor to another.

Group practice takes many forms. It includes partnerships of many kinds, private clinics, and groups sponsored by labor and management.

One type of group practice is the Health Maintenance Organization (HMO). In most HMO's, the surgeon's income does not depend on the number of operations he performs. Under the HMO concept, doctors, including surgeons, are paid as much for keeping you well as they are for treating you when you are sick.

A good HMO performs about 50 percent less surgery on its patients than a health insurance plan which compensates doctors on a per case basis. As a result, membership in a good HMO may help save you from unnecessary surgery.

Rule 12

Select a surgeon who is not too busy to give patients enough time and attention. Surgeons who handle too

many cases are bad news for the patient for obvious reasons.

The best surgeons are likely to be busy. But the "best" surgeon who must rush through an operation and must hurry past his patients is not likely to get good results. To say haste makes waste is a gross understatement when discussing surgery.

It may be difficult for you to decide if a surgeon is too busy. You can get some feel for this by observing how crowded his waiting room is and how much time he is willing to spend with you.

Rule 13

Be especially on guard if some of the operations that are most often unnecessarily performed are proposed for you. These include hysterectomies, hemmorhoidectomies, and tonsillectomies. These operations have been referred to as "remunerectomies" by some cynics (a fancy Greek derivative from the word "remuneration"). One doctor, Norman S. Miller of the University of Michigan, coined the term "hip-pocket hysterectomies" because the "only benefactor is the surgeon's wallet." (Evening Bulletin, June 8, 1972, page 25.)

Rule 14

The patient, not the doctor or surgeon, is supposed to, and is entitled to make the decision on whether to have surgery. Listen to the experts. But remember, it's still your decision. You're entitled to have the facts you need and you're entitled to decide whether or not to go ahead with the surgery.

As the title of the television show goes – "THIS IS YOUR LIFE."

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Fairbanks Memorial Hospital

1650 Cowles St.
FAIRBANKS, ALASKA 99701

OPERATED BY
LUTHERAN HOSPITALS AND HOMES SOCIETY
FARGO, NORTH DAKOTA 58102

January 28, 1976

Representative Terry Gardner
Judiciary Committee
Pouch V
Juneau, Alaska 99811

Dear Mr. Gardner:

In response to a letter from Mike Bradner, I would like to submit the following comments on the Governor's basic package on malpractice legislation. I hope the legislature will be convinced of its importance to the people of the State. I believe the package as presented is a compromise and not totally acceptable to any one group. It is more than likely to create considerable debate and I would therefore like to express some feelings to the members of your committee for them to consider in the debate.

First, I believe that any system which is evolved should guarantee the people just compensation for medical injuries sustained. But justice is no longer served by placing the entire financial burden of such compensation on the accused. In the past, this risk of financial ruin has been spread out through the use of insurance. The question now is whether or not the three hundred physicians and eighteen hospitals can continue to bear the full cost of this burden through insurance. I am told that twelve to fifteen percent of the premiums paid are actually delivered to the injured party. The remainder goes for legal and court costs, insurance administrative cost, investigative and case preparation cost, etc. On this basis, if we can expect $1,500,000 in claims in the coming year, $10,000,000 would have to be generated in premiums to cover the expected claims. Can this burden be placed entirely on the physicians and hospitals who will pass these costs on to the people or must we seek alternatives? We certainly should make the system more efficient.

Secondly, I believe that in order to make the above guarantee, it will be necessary to guarantee malpractice "coverage". Does the State have a responsibility here? I believe that it does, if only inasmuch as it licenses physicians and hospitals and offers to the public that these licensees have at least met minimal qualifications.

Probably one of the most controversial aspects of the package, as presented, is the compulsory nature of contributions to the Medical Indemnity Corporation as a requirement for licensure. If it is truly necessary to have the total health care industry as contributors in order to obtain this "coverage", then this requirement should remain. We must have the coverage. No amount of limitation of awards or decrease in the statute of limitations will encourage an immediate

inrush of insurance companies to pick up the business. An interesting offshoot of the compulsory nature of this contribution might be the incentive it gives to peer review for risk identification.

On the subject of risk identification, I believe that it is necessary only to beef up the powers and immunities of the Medical Board and to provide for a natural flow of information from the medical societies, hearing committees, expert advisory panels, etc. I would recommend against establishing a branch of government concerned with risk identification as I believe such already exist in the Medical Board.

In summary, I support the recommendations of the Advisory Committee and ask the legislature to consider that this package was an effective compromise reached in the fall of 1975. If any changes are to be made, in the light of new information, please "don't throw the baby out with the bath water".

Sincerely,

Roger F Harding

ROGER F. HARDING, M. D.
Fairbanks Memorial Hospital

RFH:nw

RECOMMENDATION OF GOVERNOR'S COMMISSION ON MALPRACTICE

RECOMMENDATION #1: The liability of the health care provider should terminate three years after occurrence (two years statute of limitations and one year limit on discovery). Any reported case after the third year ought to become the responsibility of a special fund and not the liability of the health care provider.

RECOMMENDATION #2: Any award to which the injured patient is entitled should be reduced by all available collateral sources such as private, group or governmental medical or disability benefits whether contributory or noncontributory, except life insurance, by including the introduction into evidence of the items of damage compensated by collateral sources, except federal programs which by law must seek subrogation.

RECOMMENDATION #3: Medical professionals should be immune from liability to a person who is not his patient for administering emergency medical care where the giving of immediate aid appears to be the only alternative to death or serious bodily injury or harm.

RECOMMENDATION #4: The law should provide that no promise to achieve a certain medical result is valid unless that promise is in writing signed by the health care provider.

RECOMMENDATION #5: The definition of medical negligence be improved by adopting a national standard of acceptable medical care in lieu of a local community standard, limiting the standard to that at the time of the act, and imposing the standard appropriate under all circumstances under which the health care provider was acting.

RECOMMENDATION #6: Cases brought more than three years after the date of the incident alleged to cause the loss complained of must be proven by evidence that is clear and convincing.

RECOMMENDATION #7: There be enacted provision for appointment of ad hoc medical expert panels composed of at least one physician and two health care providers of the same discipline as the health care provider charged, impanelled after filing of an action and prior to any pretrial proceedings to initiate an investigation of available evidence and report to the parties its findings as to medical facts.

RECOMMENDATION #8: The findings of the expert medical panel be admissible as evidence and the panelists subject to cross-examination in any subsequent trial.

RECOMMENDATION #9: There be established a medical adjudication board consisting of nine citizens of the State who are neither health care providers nor legal professionals, nor insurers, and three physicians appointed by the Governor, and one Superior Court judge assigned by the court. This board would be the exclusive tribunal for medical negligence cases.

RECOMMENDATION #10: The legislature enact a joint resolution for the amendment of Article I, Section 16 of the Alaska State Constitution, permitting the legislature to consider an alternative system of adjudicating medical negligence claims which may be a substitution for trial by jury.

RECOMMENDATION #11: Provisions be made to authorize and administer the awards of future income and continuing medical care to be paid periodically rather than in a lump sum.

RECOMMENDATION #12: Jury and board awards shall be rendered by category of loss.

RECOMMENDATION #13: Create a Health Care Providers Indemnity Corporation, a public corporation, which would be regulated by the Director of Insurance as a domestic property and casualty insurer and which would be a mandatory and exclusive source of minimum limits of medical malpractice insurance for all health care providers for the losses reported within the first three years after occurrence.

RECOMMENDATION #14: The corporation may contract with servicing carriers for administrative and claims services and seek contracts of indemnity from admitted carriers retaining for itself no insurable risk.

RECOMMENDATIONS #15: The rates for coverages provided by the corporation should be developed based on Alaska's experience and retrospectively adjusted over a four year period such that each category of health care providers would fully pay for all losses and expenses incurred in the programs yielding an appropriate profit to the indemnity carrier.

RECOMMENDATION #16: The corporation provide coverage retroactively to January 1, 1975 with appropriate additional premiums for those health care providers which had no insurance during that period.

RECOMMENDATION #17: A joint underwriting association should be authorized to be implemented upon a finding by the Director of Insurance that indemnity at a reasonable rate is not available from a private carrier.

RECOMMENDATION #18: The joint underwriting association should be composed of all property, casualty and disability insurers and all health care service contractors.

RECOMMENDATION #19: Create a late claims fund which shall be funded by assessments against all health care providers in amounts determined by the Director of Insurance after public hearing as necessary to actuarially carry all fund liabilities and guaranteed by the State to the extent necessary to cover actuarial deficiencies. There should also he provision for the legislature to reduce the assessment of health care providers upon a finding that the assessment is unaffordable.

RECOMMENDATION #20: Legislation should be enacted which will require the maintenance of separate, specific and detailed statistical information on malpractice claims. Authority should be exercised by the Director of Insurance to more deliberately regulate policy forms and rates for this line.

RECOMMENDATION #21: The proposals of this Commission should inure to the benefit of, and be binding upon all licensed in the State as hospitals, as defined in AS 18.20.130 chiropractors, dental hygenists, dentists, physicians, osteopaths, chiropodists, nurses, opticians, pharmacists, physical therapists, psychologists and psychological assistants.

RECOMMENDATION #22: There should be a legislatively prescribed procedure for informing the patient of the consequences of a procedure and obtaining the consent to perform it and also setting forth the conditions pursuant to which consent is implied or not required.

RECOMMENDATION #23: The appropriate licensing boards should be authorized to render disciplinar sanctions against health care providers other than license suspension. The boards should be able to reprimand, censure, place on probation, restrict practice by time, specialty, procedure or facility or to require continuing education or retraining.

RECOMMENDATION #24: The appropriate licensing board should have authority to require more relevant and more frequent reports on healthcare practices by and from its licensees. Persons reporting should have immunity from defamation actions based on reports made to licensing boards to officially constituted service committees of hospitals and professional organizations.

RECOMMENDATION #25: The legislature appropriate such additional funds as are needed to properly staff the health care licensing boards with investigative and administrative personnel.

RECOMMENDATION #26: Provision should be made for more effective loss control by all health care providers but with specific attention to identified problem areas.

STATE OF ALASKA
THE LEGISLATURE
LEGISLATIVE AFFAIRS AGENCY

POUCH Y · STATE CAPITOL
JUNEAU, ALASKA 99811
907-465-3800

MEMORANDUM

February 18, 1976

SUBJECT: Medical Malpractice Premiums by Alaskan Physicians

TO: The Honorable Terry Gardiner

FROM: Louise Crane
Research Analyst

The Division of Insurance, Department of Commerce and Economic Development has, at the request of the Legislative Affairs Agency, conducted an individual policy survey of the medical malpractice premiums of Alaskan physicians by polling each broker who markets medical malpractice insurance in Alaska. This information has been compiled as to total premiums, total premium by speciality and average premium by speciality.

The attached letter from Richard L. Block, Director of Insurance, also includes information you requested in a letter of January 30th concerning the impact of premiums if an absolute statute of limitations was adopted.

The Legislative Affairs Agency had requested the release of the information on several occassions within the past week. However, the Director of Insurance was out-of-town, and his staff was reluctant to release the compiled information without the Director's editorial review. This Agency received the attached report at 9:30 a.m., February 18, 1976.

LC:cw

ATTACHMENT

STATE OF ALASKA

JAY S. HAMMOND, Governor

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE / POUCH D— JUNEAU 99801

February 17, 1976

Terry Gardiner, Representative
House of Representatives
Pouch V
Juneau, Alaska 99811

Dear Representative Gardiner:

In response to your request for current statewide premium levels for Medical Malpractice Insurance I am pleased to provide you with the attached schedule.

Bear in mind that this is not entirely reflective of actual premiums paid for the following reason:

1. The figures used are for basic limits of $200-600,000.00 of liabiliaty. Most physicians who purchase insurance also purchase excess liability, probably to $1,000,000.00 for which there is an additional charge.

2. Some of the policies included in this survey are on a claims made form and in order to obtain protection for claims made during a tail period, an additional charge will have to be made at a later date. Those charges are not included in the premium figures.

The fact that some of the policies reported are on claims made form and some are on occurrence form tends to also distort the picture.

Finally, many of the physicians are insured under a very favorable program offered to the American Group Practice Association. In order to show this spread of premiums in each class, the attached chart has a column for the low and the high premiums which were reported to us.

You also asked what the difference would be in premium level should the Medical Malpractice Insurance Commission's proposals be adopted. The most frank answer I can give is, I don't know. Perhaps it would be helpful for you to consider the following points:

1. Under the Commission's recommendation there would be two charges:

   A. A charge for coverage of claims reported within three years. Since the coverage provided is similar to that provided under the Lloyd's claims made form with three years of automatic tail protection and similar to the Shand Morahan program which provides three years tail protection upon the payment of a specified additional charge,that the Lloyd's premium or the Shand Morahan premium with additional charge will provide some indication of current premium levels for the coverage provided by the M.I.C.

   B. The charges to support the late claims fund will probably key off of some of the Closed Claims Survey Information which shows that approximately 6% to 10% of the dollars which have been paid out have been with respect to claims reported after 36 months after date of occurrence.

2. The Commission's recommendation requires the rate to be based on Alaska experience which means that if a lower than average number of claims were reported, this should be reflected in the lower than average premium level. We are currently obtaining a list of currently outstanding claims and claims which have been closed. It would appear that the total cost of all claims averaged over any four year period, is currently less than the present premium level, that is to say, the Alaskan experience has been more favorable than is indicated by the cost of the increasing rates. Any new rate will have to allow for the potential for increased frequency and larger size of losses that could be anticipated as Alaskans become more aware of the malpractice situation and the propensity to file a suit is increased but as the rating mechanism is rolled forward over the four year period, past history would suggest that the factors causing substantial rate increases in other states would not be present in the State of Alaska.

3. The Insurance Service Office which promulgates rates for its member carriers, indicated at the Malpractice Insurance Commission hearings in Anchorage, and frankly in more recent discussions, maintained, that were they to make a new filing of rates for their members, based on Alaskan experience, the rates would be lower than they have been in the past because of the favorable claim experience.

4. The present rates reflect expense factors, many of which will not be present in the mechanisms proposed by the Commission. Some examples are:

   A. Taxes are reduced by 1 1/2% of the total premium.

   B. Producer costs (agency and brokerage commissions) would be substantially reduced, I would estimate by 5 to 20% of the total premiums.

   C. General and overhead expenses can conceivably be substantially reduced but it is difficult to estimate by how much at this time.

   D. If the Commission's proposals concerning tort reform is adopted, it is believed that defense costs will be materially reduced.

   E. Because the program will be reinsured as a separate entity it is expected that reinsurance costs will be higher than they would be if the program were insured by a national carrier as part of an overall program but this could be offset by the fact that on a long term basis, reinsurance costs are a function of experience and if the experience is good the cost for reinsurance will be reduced even for a small sized book of business.

You have asked by your letter of January 30th, what the impact of premiums would be if we adopted an absolute statute of limitations similar to that enacted in California, Florida, Indiana, and Oregon. Carriers will anylize the effect of that law probably taking into account three considerations.

1. The current loss development data available suggests that approximately 6% of the indemnity paid is in respect to claims which were reported over three years after date of occurrence with respect to adults and 18% with respect to minors. These figures are not large, suggesting that the concern of the carriers and the dramatically increased bulk reserves to cover these losses might be partially unwarrented.

2. At the same time those figures reflect experience on cases which were reported in prior periods and closed after July 1, 1975 and prior to the close of the reporting period for the December 1975 N.A.I.C. Closed Claims Survey Report. It is reasonable to expect that wider knowledge of the malpractice suit remedy will result in more law suits and thus a larger

share of late claims which will tend to justify higher bulk reserves thus an absolute limit on time in which to file a suit could have a substantial favorable impact on costs beyond the amount indicated in subparagraph 1 above.

3. The principle concern which carriers will continue to harbor is whether such a statute is an unconstitutional infringment of the right of due process. Until that matter is finally determined by a e U.S. Supreme Court opinion, the carriers will remain concerned notwithstanding the enactment of such a State law, and will establish reserves to cover the eventuality that valid claims could be filed after the running of the statute.

It could be concluded that the enactment of a statute of limitations law would certainly not cause an increase in rates and might in future years as experience develops cause the rates to be reduced.

Yours cordially

Richard L. Block
Director

PRESENT PRIMARY MALPRACTICE COST ESTIMATES

SPECIALTY	CLASS	HIGH PREMIUM	LOW PREMIUM	AVERAGE PREMIUM	NO. DOCTORS AVERAGE DERIVED FROM	TOTAL DOCTORS	TOTAL PREMIUM
General Surgery	4*	12,084	2,463	7,509	7	48	$360,432
Family Practice	1	3,909	625	1,446	22	155	224,130
Orthopedic Surgery	6*	14,501	2,363	12,084	11	25	302,100
Ophthalmology	3*	9,126	1,478	4,851	4	20	97,020
OB GYN	5*	3,918	2,955	9,126	6	34	310,284
Otolarngology	4*	7,509	6,219	7,509	3	12	90,108
Internal Medicine	1	4,851	484	1,111	14	60	66,660
Radiology	2	17,464	484	4,138	8	14	57,932
Pediatrics	1	1,478	484	1,050	10	40	42,000
Pathology	1	4,162	2,605	3,383	2	12	40,608
Urology	3*	2,238	1,970	4,851	2	6	29,106
Neurologist	1	550	550	550	1	8	4,400
Acupuncture	1	1,019	1,019	1,019	1	1	1,019
Anesthesiology	6*	12,084	7,500	12,084	1	14	169,176
Plastic Surgery	5*	9,126	2,955	9,126	class 5 av.	3	27,378
Psychiatry	1	1,101	484	1,035	" 1 "	29	30,015
Dermatology	1	1,101	484	1,035	" 1 "	4	4,140
						485	$1,856,508

*Average for this class not credible or available. Utilize current available premium shown as average.

Average Premium 3,830

Block

STATE OF ALASKA

JAY S. HAMMOND, Governor

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE / POUCH D — JUNEAU 99801

February 18, 1976

Alaska State House of Representatives
Judiciary Committee
In Session
Juneau, Alaska

Attention: Terry Gardiner, Chairman

Dear Representatives:

Re: Committee substitute for HB 574

I have reviewed what I believe is the last available draft of the above referenced measure. I would suggest that the following technical changes be made:

Adopted

1. In subparagraph 8 of the several statutes requiring insurance for a health care provider it is provided that the Commissioner of Commerce and Economic Development may require all persons licensed to obtain the insurance required. This is essentially a determination involving knowledge of the markets, underwriting requirements, rates and trends in the insurance industry and falls within the special purview of the Director of Insurance. I believe that in all of those sections the Director of Insurance whould be substituted for the Commissioner of Commerce and Economic Development. This recommended change is endorsed by the Commissioner of Commerce and Economic Development.

2. On page four, line three, I recommend that there be added as follows:

   "...in the required amounts[.] issued by the Health Care Provider Indemnity Corporation."

OK

This recommendation is made to be sure that all physicians are insured in the corporation even though they are insured through an employers policy. This means that if the hospital procures insurance from the Health Care Provider Indemnity Corporation and covers its physicians, the physician has satisfied his insurance requirement. On the other hand if the physician is employed by a corporate employer, the only way that the provision could be satisfied is if the corporate employer purchased malpractice insurance for the physician through Health Care Providers Indemnity Corporation.

3. Page 10. It was intended by the Malpractice Commission that the expert advisory panel be composed of health care providers That is not specifically required in the existing section. I would suggest that lines 15, 16, and 17 be amended as follows:

OK

> "...professional services by a health care provider, the court shall establish [a three person] an advisory panel of three health care providers in accordance with this section."

4. Page 12. (g) The measure prohibits consultation among the partys counsel and the advisory panel except through ordinary discovery proceedings. This clearly defeats the purpose of having the advisory panel. As written the section would prohibit the panel from interviewing or discussing the matter with the defendant doctor and would require that depositions and interrogatories be used to extract information. It is the purpose of the advisory panel to eliminate the expense of these discovery proceedings, not to encourage it. I would suggest that nothing is served by prohibiting communications with the advisory panel and thus subsection (g) should be stricken.

NO

5. Section 09.55.550 would strike the words "BY A PREPONDERANCE OF THE EVIDENCE", and refer instead to Section 09.55.540. This latter section contains no statement as to the quantum of proof required to make a case. There seems to be lack of unanimity what quantum of proof is required, but I certainly believe that justice is better served if the Legislature will finally determine the quantum of proof and state it in a statute clearly. It could be stated either in Section 540 or Section 550.

OK

I would still commend substantively, that with respect to cases reported longer than three years after incident, the quantum of proof should be "clear and convincing" and the quantum of proof for other cases should be "by a preponderance of evidence."

OK 6. Page 13. I believe that awards for loss of future earnings should be permissive and not mandatory, thus the word "shall" in line 27 should be changed to "may".

OK 7. On page 14, line 1, there is reference to the concept of increasing the award by an interest rate factor. It is unclear whether it is intended to provide for an escalation in the value of the periodic payment to cover inflation or whether it is trying to define the discount factor in establishing

a reserve for fixed periodic payments. If the desire is to protect against inflation then I would suggest that the language be amended as follows: Insert p. 14, l 1 after "basis"

"...periodic payments rather than by a lump sum payment; however the amount of periodic payment shall be increased annually in the same proportion as annual increases in the consumer price index for the community in which the claimant resides."

Adopted

On the other hand, if the application of a discount factor is the objective, then the following language should be used:

"...periodic payments rather than by a lump sum payment: however, any part of the award which is paid on periodic basis shall be reserved as an actuarialy calculated annuity utilizing tables and rates for annuity reserves currently approved by the Division of Insurance.

8. The provision in the subrogation section is impossible of implimentation. On page 14, line 11 it provides that evidence of collateral sources are admissable after the fact finder has rendered its award. Presumably the fact finder is a jury and once a jury has rendered its award there is no opportunity to present additional evidence. I would suggest the most workable solution is to strike from line 13, the language "after the fact finder has rendered its award." See p. 14

Tested

9. Page 16, line 21 should be amended to read:

"...liability per year of not less than one million dollars plus an additional twenty thousand dollars for each bed over fifty beds for which the hospital is licensed."

Adopted

10. Page 25, line 16. retroactive insurance provision should be changed to read as follows:

at the option of the h-c -p

"...(B) that arise out of services performed by the health care provider after December 31, 1974 for any period in which the health care provider had no malpractice insurance except that coverage will not be provided for a claim already filed or of which the health care provider has or reasonably should have had notice at the time retroactive insurance is purchased."

Adopted

11. I believe that the rating provision should be amended in order to make the charges to physicians track as closely as possible with the intended controll costs intended by the Commission. That may by accomplished within the context of current insuring structures in this measure by amending the rating law as follows. Page 28, line 10:

"...unpaid, reserves for claims incurred during the policy period but not reported but reasonably expected to be reported within three years after the date of incident ~~and~~ reasonable..."

Adopted

The same change should take place in lines 16 and 17. Also change reserve requirement p25

There should be added an additional factor in establishing the rate as follows:

Adopted

"(12) an amount sufficient to repay any loan obligation".

Yours cordially,

Richard L. Block
Director

BOARD OF GOVERNORS

ALASKA BAR ASSOCIATION

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January 22, 1976

RECEIVED
JAN 23 1976
Office of Chief Justice
Supreme Court of Alaska
Juneau

Honorable Robert Boochever
Chief Justice
Alaska Supreme Court
Pouch "U"
State Court and Office Building
Juneau, Alaska 99811

Re: Expert Medical Panel Proposed For Use In Medical Malpractice Cases

Dear Mr. Chief Justice:

The court has asked for the Alaska Bar Association's comments concerning the use of expert medical panels in medical malpractice cases as proposed by the Governor's Task Force. My response is necessarily a qualified one to the extent that it must be noted that there is by no means unanimity on this subject among Alaska's lawyers. However, with the assistance of the Alaska Bar's Special Committee on Medical Malpractice, chaired by Anchorage attorney, Joe Young, we have the following comments concerning that proposal:

Perhaps the most important objection to the proposed panel is directed at the underlying premise, i.e., that a jury of lay persons is unable to understand the type of medical evidence presented in a medical malpractice case. That premise is fallacious at best. Any attorney who has ever been involved in a personal injury case requiring the use of medical testimony can attest to the ability of a jury to comprehend and evaluate such testimony. Most physicians demonstrate remarkable skill as witnesses in terms of their ability to reduce complex medical terminology to succinct explanatory remarks. To the extent that the proposed expert medical panel finds its genesis in the notion that jurors are simply not able to grasp the complexities of medical testimony, it is not well founded.

As to the suggestion that such panels are necessary because the parties are too often led down the primrose path to misguided litigation by their own biased medical experts, there is some room for discussion. While it may be true that in a few instances parties (and their attorneys) may be misled by their own overzealous experts, there is no evidence that this has occurred in Alaska. Responsible counsel will consult with independent experts in an effort to determine the validity of a potential malpractice claim.

It is possible that a voluntary screening panel plan such as that used in Arizona or Colorado might be of some utility in weeding out nonmeritorious claims. I am enclosing copies of both the Pima County (Arizona) and Colorado plans. Neither of those measures features a panel comprised solely of members of the medical profession. Those plans do perform a public service to the extent that they may tend to discourage pursuing a suit which is clearly without merit and to the extent that they provide patients with relatively small claims an economical forum for evaluation of their cases. Unfortunately, these plans have not been successful in reducing professional liability insurance rates.

There is a more technical objection to the use of an expert medical panel as proposed by the task force which must be given at least passing mention. Based on the information available to us, it appears that the panel would be free to accept evidence without regard to strict legal standards relating to admissibility. The panel would be free to incorporate such evidence into its findings and that evidence would in turn be admissible without further foundation or qualification. That prospect should prove frightening to doctor and patient alike.

The cost factor of medical malpractice litigation is likely to increase substantially if an expert medical panel plan is implemented. In order to gain an initial advantage at trial from the use of favorable medical panel findings, both parties would have to prepare for hearings before the panel in the same manner as if they were going to trial. In effect, the parties would be put to the added and unnecessary expense of trying their case twice. From the bar association's point of view, it is difficult to see how either the medical profession or the public would be well served by such an inherently expensive procedure.

There is an additional legal objection to the use of a medical expert panel which is simply that the proposal appears potentially violative of Article 1, §1 of the Alaska Constitution which provides in part that "all persons are equal and entitled to equal rights, opportunities, and protection under the law". It is my understanding that a compulsory screening panel plan was struck down on equal protection grounds in Tennessee. The possibility that this proposal may suffer from similar constitutional infirmities cannot be ignored.

A careful review of the Task Force's findings provides no empirical data from which it is possible to infer that the creation of a medical expert panel is either necessary or desirable. Indeed, there is no evidence to suggest that juries are somehow incapable of properly resolving these cases.

In its present form, the expert medical panel bears little resemblance to the voluntary screening panel proposed by the Alaska Bar nearly five years ago. That plan had the virtue of being optional and at least paid lip service to the notion that objectivity in the review of such matters should and could be maintained. The panel proposed by the task force would consist of one physician and two other health care providers of the same health care provider charged. Thus, in the instance of a malpractice claim against a physician, the expert panel would be composed entirely of physicians. While we may all be convinced of the integrity of the physicians elected for service on such a panel, the appearance of impropriety may be raised merely by the panel's composition.

I wish I could report that the Alaska Bar Association has devised a means by which the current medical liability insurance crisis could be resolved. Unhappily, that is not the case. Despite the high quality of medical care rendered to Alaskans, the sad fact is that we are simply the tip of the proverbial iceberg, controlled in this case by events of national magnitude. While I have not been shown any accurate figures relating to premium/loss ratio in Alaska, I would estimate that the premium revenue far outstrips the relatively few losses paid out for medical maloccurrences. Alaska's physicians are being asked to pay for a national loss experience and are probably paying the price of the losses of the insurance industry in the stock market.

As things presently stand, a workable joint underwriting association bill seems to have the greatest possible chance to stabilize the current insurance picture. I should add that in all likelihood the bar's own insurance problems will follow closely on the heals of those currently confronting the medical profession. Our own arrangements for a group E & O policy has given us a considerable amount of information relating to cancellations by a number of carriers previously writing E & O coverage in Alaska. Premiums are going up, and will continue to escalate; moreover, and it is almost inevitable that members of the bar will be relegated to purchasing "claim made" as opposed to the more desirable "per occurrence" coverage. With that thought in mind, I believe that the organized bar is sympathetic to the plight of the medical profession. But, I trust that when our turn comes we will not be advancing our own proposal for a "legal expert board".

It is possible that a voluntary arbitration plan similar to that now offered in Michigan might prove to be of some benefit, but a consideration of such alternatives is beyond the scope of this letter. Suffice it to say that from the bar's point of view and, I expect, from the public's, the proposed medical expert panel has nothing to commend it.

If the bar can be of any assistance to the court, please contact me.

Very truly yours,

Keith E. Brown
President

KEB:wj

Enclosures

cc: Joe Young
BOG Members
Mary LaFollette

Mandatotily group

~~Opt~~ in insurance for other groups

1. Direct/ has hearing then

Mandatotily includes a group

He uses a standard of impairment of

delivery of that healthcare system

to the public

Expert Advisory panel of 3 Mandatotily appointed by court – No list of challenge procedure – ~~Appointees from profession~~ ~~the case involves~~ Judge has discretion on composition only limit to health care provider eliminate "Alaska ~~Area~~ residency

Add language "when possible select Alaskan Health

Change "health care provider"

to "Medical care provider"

Pear

John Hedland

large settlements not the problem

high cost of experts for cases

3

HEW defense att receive more legal fees

system designed to require a lot of legal work

Expert Advisory Board - Report to court

What is cheaper about Advisory Board ?
Is the problem juries don't have enough info ?
Why is a 3rd opinion better ?
What if Advisory Board is split ?
What happens to all fees if court costs in cases now ?

Cost Award would allow Adjudication Board

Expand Small Claims Court set-up

What is cheaper about Adj. Board over Jury
What really is so expensive about Jury

Mandatory arbitration is further from Jury type system - No judge present

if not Mandatory have 2 courts
What about pre-liminary hearings & Grand Jury
Penalize for loss in appealing - Test strength of case

loser pays costs

1. - Physician - Advisement - Have Grievance Committee
2. Physician

Draft 3 Wed feb 18

Original sponsor: Rules Committee by request of the Governor

IN THE HOUSE BY THE JUDICIARY COMMITTEE

CS FOR HOUSE BILL NO. 574

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to liability for the provision of health care services; changing the Alaska Supreme Court's Rules of Civil Procedure; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 08.01.050 is amended by adding a new paragraph to read:

Broader disciplinary powers

(19) provide investigative services to the boards established under chs. 20, 32, 36, 64, 68, 71, 72, 80, 84, and 86 of this title, for the purpose of assisting those boards in matters of professional discipline.

* Sec. 2. AS 08.20 is amended by adding new sections to read:

Chiropractors

Sec. 08.20.115. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance against liability to patients for chiropractic malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The commissioner of commerce and economic development may require all persons licensed under this chapter to obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for chiropractors is impairing the delivery of chiropractic services to the public.

Sec. 08.20.125. [illegible] REPRIMAND. (a)

In addition to action under sec. 170 of this chapter, upon a finding that by reason of demonstrated lack of competence, experience, or education the authority to practice chiropractic should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 3. AS 08.32 is amended by adding new sections to read:

Deletion to Dental Hygienist

Sec. 08.32.015. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if the person's employer maintains insurance for him in the required amounts.

(b) The commissioner of commerce and economic development may require all persons licensed under this chapter to obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for dental hygienists is impairing the delivery of dental hygienists' services to the public.

Sec. 08.32.165. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 160 of this chapter, upon a finding that by reason of demonstrated competence, experience, or education the authority to practice dental hygiene should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 4. AS 08.36 is amended by adding new sections to read:

Dentists

Sec. 08.36.115. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance against liability to patients for dental malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The commissioner of commerce and economic development may require all persons licensed under this chapter to obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for dentists is impairing the delivery of dentist services to the public.

Sec. 08.36.325. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 320 of this chapter, upon a finding that by reason of demonstrated competence, experience, or education the authority to practice dentistry should be limited or conditioned or the practitioner disciplined, the board may censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 5. AS 08.64 is amended by adding new sections to read:

Physicians Laboratory

Sec. 08.64.215. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance issued by the Health Care Providers Indemnity Corporation against liability to patients for medical malpractice in limits of not less than

$200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The commissioner of commerce and economic development or his designee may waive the requirement in (a) of this section for a person if that person furnishes satisfactory evidence of his having other insurance providing coverage in amounts not less than those specified in (a) of this section. No waiver granted under this subsection may extend beyond the normal expiration date of the person's insurance policy or January 1, 1977, whichever occurs first.

Sec. 08.64.312. CONTINUING EDUCATION REQUIREMENTS. (a) The board shall promote a high degree of competence in the practice of medicine by requiring every physician licensed in the state to fulfill continuing education requirements. extent of continuing education determined by Board

(b) Before a license may be renewed the licensee shall submit evidence satisfactory to the board of his successful completion of 15 hours of continuing education annually in medicine as prescribed by regulations of the board. Courses approved by the board shall include, but are not limited to, review courses and instruction on new techniques and developments in medicine.

(c) The board may exempt a physician from the requirements of (b) of this section upon an application by him giving evidence satisfactory to the board that he is unable to comply with the requirements because of extenuating circumstances. However, no person may be exempted from more than 15 hours of continuing education in a five year period.

Sec. 08.64.325. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 330 of this chapter, upon a finding that by reason of demonstrated competence, experience, or education the authority to practice under this chapter should be limited or condi-

tioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 6. AS 08.68 is amended by adding new sections to read:

Nurses

Sec. 08.68.165. INSURANCE REQUIRED. (a) To be eligible for an active license as a nurse under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts. If employed

(b) The commissioner of commerce and economic development may require all persons licensed under this chapter to obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for nurses is impairing the delivery of nurse services to the public.

Sec. 08.68.275. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 270 of this chapter, upon a finding that by reason of demonstrated competence, experience, or education the authority to practice nursing should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

Sec. 7. AS 08.71 is amended by adding new sections to read:

dispensing opticians

Sec. 08.71.085. INSURANCE REQUIRED. (a) To be eligible for an

active license under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The commissioner of commerce and economic development may require that all persons licensed under this chapter obtain the insurance required under (a) of this section if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for dispensing opticians is impairing delivery of the services of dispensing opticians to the public.

Sec. 08.71.175. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 170 of this chapter, upon a finding that by reason of demonstrated competence, experience, or education the authority to practice as a dispensing optician under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by procedure or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 8. AS 08.72 is amended by adding new sections to read:

Optometrists

Sec. 08.72.115. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The commissioner of commerce and economic development may require all persons licensed under this chapter to obtain insurance

required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for optometrists is impairing delivery of optometrist services to the public.

Sec. 08.72.255. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under secs. 240 and 250 of this chapter, upon a finding that by reason of demonstrated competence, experience, or education the authority to practice optometry under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 9. AS 80.80 is amended by adding new sections to read:

Pharmacists

Sec. 08.80.115. INSURANCE REQUIRED. (a) To be eligible for active registration as a pharmacist, a person must maintain insurance against liability to patients for malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The commissioner of commerce and economic development may require that all persons licensed under this chapter obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for pharmacists is impairing delivery of pharmacist services to the public.

Sec. 08.80.265. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 260 of this chapter, upon a finding that by reason of demonstrated competence, experience, or education the

authority to practice pharmacy under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 10. AS 08.84 is amended by adding new sections to read:

Physical therapists

Sec. 08.84.035. INSURANCE REQUIRED. (a) To be eligible for active registration as a physical therapist under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The commissioner of commerce and economic development may require that all persons licensed under this chapter obtain the insurance required in (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for physicial therapists is impairing delivery of physical therapist services to the public.

Sec. 08.84.185. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 180 of this chapter, upon a finding that by reason of demonstrated competence, experience, or education the authority to practice physical therapy should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 11. AS 08.36.120 is amended to read:

Sec. 08.86.120. ENTITLEMENT TO LICENSURE. A person who passes the examination given by the board and possesses the insurance required by sec. 125 of this chapter is entitled to be licensed as a psychologist

* Sec. 12. AS 08.86.160 is amended to read:

Sec. 08.86.160. ASSOCIATES: ENTITLEMENT TO LICENSURE. A person who passes the examination given by the board and who possesses insurance in accordance with sec. 125 of this chapter is entitled to be licensed as a psychological associate.

* Sec. 13. AS 08.86 is amended by adding new sections to read:

Sec. 08.86.125. INSURANCE REQUIRED. (a) To be eligible for active licensure as a psychologist under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The commissioner of commerce and economic development may require all persons licensed under this chapter to obtain insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for psychologists is impairing the delivery of psychologist services to the public.

Sec. 08.86.220. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) Upon a finding that by reason of demonstrated competence, experience, or education the authority to practice psychology or as a psychological associate under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by time, specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any

action taken by the board under this section.

* Sec. 14. AS 09.55.530 is repealed and re-enacted to read:

ARTICLE 6. MALPRACTICE ACTIONS.

Sec. 09.55.530. DECLARATION OF PURPOSE. The legislature finds that the health of the people is threatened by curtailment of health care services due to the difficulty in obtaining adequate malpractice insurance at a reasonable cost. It is the purpose of secs. 530 - 560 of this chapter to protect the health and safety of the people of this state by establishing procedural aids for handling malpractice claims which will help ensure the ready availability of adequate insurance at a reasonable cost and which will be fair to all parties concerned.

* Sec. 15. AS 09.55 is amended by adding a new section to read:

Sec. 09.55.536. EXPERT ADVISORY PANEL. (a) In any action for damages due to personal injury or death based upon the provision of professional services by a health care provider, the court shall establish a three-person expert advisory panel in accordance with this section. When the action is filed the court shall, by order, determine the professions or specialties to be represented on the expert advisory panel and shall advise each party of the professions or specialties to be represented, giving the parties the opportunity to object or make suggestions. The court may in its discretion conduct other preliminary proceedings relative to the composition of the panel as it considers appropriate.

(b) The expert advisory panel may compel the attendance of witnesses, ~~physically or orally examine the parties~~ interview the parties and physically examine the injured persons if alive, consult with the specialists or learned works they consider appropriate, and compel the production of and examine all relevant hospital, medical, or other records or materials relating to the health care treatment. The panel may meet in camera, but shall maintain a record of any testimony or oral statements

of witnesses, and shall keep copies of all written statements and opinions it receives. Not less than 30 days after selection of the panel, it shall make a written report to the parties and to the court, substantially answering the following questions in addition to any other question which the court puts to the panel:

(1) Was the claimant adversely affected by any act or omission in the rendering of the medical services?

(2) What was the adverse effect?

(3) How did the medical services alter the natural course of the preexisting disorder for which the services were originally rendered?

(4) How did the medical condition existing after performance of the medical services differ from the medical condition which might otherwise have been expected?

(c) In any case in which the answer to one or more of the questions under (b) of this section depends upon the resolution of factual questions which are not the proper subject of expert opinion, the report shall so state and may answer questions based upon hypothetical facts that are fully and completely set out in the opinion. The report shall include copies of all written statements, opinions, or records relied upon by the panel and either a transcription or other record of any oral statements or opinions; shall specify any medical or scientific authority relied upon by the panel; and shall include the results of any physical or mental examination performed on the plaintiff. Each member shall sign the report and his signature constitutes his adoption of all statements and opinions contained in it; however, a member may, instead of signing the report, submit a concurring or dissenting report which complies with the requirements of this subsection, and a member may not attest to any portion of the report as to which he is not qualified to

give expert testimony.

(d) No discovery may be undertaken in a case until the report of the expert advisory panel is received. However, the court may relax this prohibition upon a showing of good cause by any party. If the panel has not completed its report within the 30-day period prescribed in (b) of this section, the court may, upon application, grant it an additional 30 days.

(e) The report of the panel and any dissenting or concurring opinion are admissible in evidence to the same extent as though its contents were orally testified to by the person or persons preparing it. The court shall delete any portion that would not be admissible because of lack of foundation for opinion testimony, or otherwise. Either party may submit expert testimony to support or refute the report. The jury shall be instructed in general terms that the report shall be considered and evaluated in the same manner as any other expert testimony. Any member of the panel may be called by any party and may be cross-examined as to the contents of the report or of his dissenting or concurring opinion.

(f) Members of a panel are entitled to travel expenses and per diem in accordance with state law pertaining to members of boards and commissions for all time spent in preparing its report and matters incidental to it. If a panel member is called upon as a witness at trial or upon deposition, he is entitled to payment of an expert witness fee. All expenses incurred by the panel shall be paid by the state. However, in any case in which the court determines that a party has made a patently frivolous claim or a patently frivolous denial of liability, it shall order that all costs of the expert advisory panel be borne by the party making that claim or denial.

(g) Parties to the case, and their counsel, may not, communicate ~~ex-~~ initiate ex with

~~of court with~~ members of the panel on the subject matter of its inquiry and report or cause or solicit others to do so, except through ordinary discovery proceedings.

* Sec. 16. AS 09.55.540 is amended to read:

Sec. 09.55.540. BURDEN OF PROOF. (a) In a malpractice action based on the negligence or wilful misconduct of a health care provider [PHYSICIAN LICENSED UNDER AS 08.64, OR A DENTIST LICENSED UNDER AS 08.36], the plaintiff has [SHALL HAVE] the burden of proving #6

(1) the degree of knowledge or skill possessed or the degree of care ordinarily exercised under the circumstances, at the time of the act complained of, by health care providers in the field or specialty in which the defendant is practicing [BY PHYSICIANS OR DENTISTS PRACTICING THE SAME SPECIALTY IN SIMILAR COMMUNITIES TO THAT IN WHICH THE DEFENDANT PRACTICES];

(2) that the defendant either lacked this degree of knowledge or skill or failed to exercise this degree of care; and

(3) that as a proximate result of this lack of knowledge or skill or the failure to exercise this degree of care the plaintiff suffered injuries that would not otherwise have been incurred.

(b) In malpractice actions there is [SHALL BE] no presumption of negligence on the part of the defendant.

* Sec. 17. AS 09.55 is amended by adding a new section to read:

Sec. 09.55.546. AWARDS, COLLATERAL SOURCES. (a) In a malpractice action damages shall be awarded according to the principles of the common law. The fact finder, in rendering its award for damages, shall specify the amount awarded for each category of loss; [~~Awards for~~ computing loss of future earnings ~~shall be made~~ on a monthly basis.] The court may enter a judgment that future damages be paid in whole or in part by periodic payments rather than by a lump sum payment; however, any part

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of the award which is paid on periodic basis] shall be increased by an annual interest rate of seven per cent from the date the award is made. In this subsection, future damages include damages for future medical treatment, care or custody, loss of future earnings, or loss of bodily function of the claimant.

(c) Except when the collateral source is a federal program which by law must seek subrogation, an award to which a claimant is entitled may only cover damages which exceed any amounts received by the claimant as compensation for his injuries from collateral sources, whether private, group, or governmental, and whether contributory or noncontributory, except life insurance. Evidence of ~~damages compensated~~ by a collateral source, or lack thereof, other than a federal program which must seek subrogation, is admissible after the fact finder has rendered its award. Notwithstanding other provisions of state law and except as provided in this subsection, a collateral source does not have a right of subrogation.

* Sec. 18. AS 09.55.550 is amended to read:

Sec. 09.55.550. JURY INSTRUCTIONS. In health care [MEDICAL] malpractice actions the jury shall be instructed that the plaintiff has the burden of proving [, BY A PREPONDERANCE OF THE EVIDENCE,] the health care provider's negligence or wilful misconduct in accordance with sec. 540 of this chapter [OF THE PHYSICIAN OR DENTIST]. The jury shall be further instructed that injury alone does not raise a presumption of the health care provider's [PHYSICIAN'S OR DENTIST'S] negligence or misconduct.

* Sec. 19. AS 09.55 is amended by adding new sections to read:

Sec. 09.55.556. INFORMED CONSENT. (a) A health care provider is liable for failure to obtain the informed consent of a patient if the claimant establishes by a preponderance of the evidence that the provider

has failed to inform the patient of common risks and reasonable alternatives to the proposed treatment or procedure, and that, but for that failure, the claimant would not have consented to the proposed treatment or procedure.

(b) It is a defense to any action for health care malpractice based upon an alleged failure to obtain such an informed consent that

(1) the risk not disclosed is too commonly known or is too remote to require disclosure;

(2) the patient stated to the health care provider that he would undergo the treatment or procedure regardless of the risk involved, or that he did not want to be informed of the matters to which he would be entitled to be informed;

(3) under the circumstances consent by or on behalf of the patient was not possible; or

(4) the health care provider, after considering all of the attendant facts and circumstances ~~[and consulting with no other health care providers]~~ used reasonable discretion as to the manner and extent to which the alternatives or risks were disclosed to the patient because he reasonably believed that the manner and extent of such a disclosure would reasonably be expected to adversely and substantially affect the patient's condition.

Sec. 09.55.560. DEFINITIONS. In secs. 530 - 560 of this chapter

(1) "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; and

a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital;

(2) "panel" means an expert advisory panel established under sec. 536 of this chapter.

* Sec. 20. AS 09.65.090 is repealed and re-enacted to read:

Sec. 09.65.090. CIVIL LIABILITY FOR EMERGENCY AID. (a) A person, at a hospital or at any other location, who renders emergency care or emergency counseling to an injured, ill, or emotionally distraught person who reasonably appears to the person rendering the aid to be in immediate need of emergency aid in order to avoid serious harm or death is not liable for civil damages as a result of an act or omission in rendering emergency aid.

(b) This section does not preclude liability for civil damages as a result of gross negligence or reckless or intentional misconduct.

* Sec. 21. AS 18.20 is amended by adding new sections to read:

Sec. 18.20.045. INSURANCE REQUIRED. Every hospital, as a condition of licensure, shall submit to the department and maintain evidence of insurance against liability to inpatients and outpatients for malpractice issued by the Health Care Providers Indemnity Corporation, in amounts of not less than $200,000 per occurrence, and an aggregate liability per year of not less than $1,000,000 for every 50 beds or fraction of that number for which the hospital is licensed.

Sec. 18.20.075. RISK MANAGEMENT. (a) To be eligible for a license each hospital shall have in operation an internal risk management program which shall

(1) investigate the frequency and causes of adverse incidents in hospitals which cause injury to patients;

(2) develop and implement measures to minimize the risk of injury to patients from adverse incidents; in developing these measures

its medical staff's

each hospital shall take into account recommendations of private underwriters, industry standards, experience of other hospitals, and recommendations of licensing boards of other health care providers; and

(3) analyze patient grievances which relate to patient care.

(b) The department shall adopt by regulation and submit to the legislative administrative regulation review committee prior to implementation standards for risk management programs in hospitals in the state which may vary according to the size of the hospital, the type of care offered by the hospital, and other factors found relevant by the department.

* Sec. 22. AS 18 is amended by adding a new chapter to read:

CHAPTER 23. HEALTH CARE SERVICES INFORMATION.

Sec. 18.23.010. LIMITATION ON LIABILITY FOR PERSONS PROVIDING INFORMATION TO REVIEW ORGANIZATION. (a) No person providing information to a review organization is subject to action for damages or other relief by reason of having furnished that information, unless the information is false and the person providing the information knew or had reason to know the information was false.

(b) No privilege of confidentiality arising from a physician-patient relationship may be invoked to withhold pertinent information from review by a review organization.

Sec. 18.23.020. LIMITATION ON LIABILITY FOR MEMBERS OF REVIEW ORGANIZATIONS. No person who is a member or employee of, or who acts in an advisory capacity to, or who furnishes counsel or services to, a review organization is liable for damages or other relief in an action brought by a person whose activities have been or are being scrutinized or reviewed by a review organization, by reason of his performance of a duty, function or activity of the review organization, unless the performance of the duty, function or activity was motivated by malice

toward the affected person. No person is liable for damages or other relief in an action by reason of his performance of a duty, function, or activity as a member of a review organization or by reason of a recommendation or action of the review organization when the person acts in the reasonable belief that his action or recommendation is warranted by facts known to him or to the review organization after reasonable efforts to ascertain the facts upon which the review organization's action or recommendation is made.

Sec. 18.23.030. CONFIDENTIALITY OF RECORDS OF REVIEW ORGANIZATION. (a) Except as provided in (b) of this section, all data and information acquired by a review organization, in the exercise of its duties and functions, shall be held in confidence, may not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review organization, and is not subject to subpoena or discovery. Except as provided in (b) of this section, no person described in sec. 20 of this chapter may disclose what transpired at a meeting of a review organization except to the extent necessary to carry out one or more of the purposes of a review organization, and the proceedings, ~~and~~ records guidelines of standards of a review organization are not subject to discovery or introduction into evidence in a civil action against a health care provider arising out of the matter which is the subject of consideration by the review organization. Information, documents, or records otherwise available from original sources are not immune from discovery or use in a civil action merely because they were presented during proceedings of a review organization, nor may a person who testified before a review organization or who is a member of it be prevented from testifying as to matters within his knowledge, but a witness may not be asked about his testimony before a review organization or opinions formed by him as a result of its hearings, except as provided in (b) of this section.

(b) Testimony, documents, proceedings, records, and other evidence adduced before a review organization that are otherwise inaccessible under this section may be obtained by a health care provider who claims that denial is unreasonable or may be obtained under subpoena or discovery proceedings brought by a plaintiff who claims that information provided to a review organization was false and claims that the person providing the information knew or had reason to know the information was false.

(c) Nothing in this chapter prevents a person whose conduct or competence has been reviewed under this chapter from obtaining, for the purpose of appellate review of the action of the review organization, any testimony, documents, proceedings, records and other evidence adduced before the review organization.

Sec. 18.23.040. PENALTY FOR VIOLATION. Other than as authorized by sec. 30 of this chapter, a disclosure of data and information acquired by a review committee or of what transpired at a review meeting is a misdemeanor and punishable under AS 11.05.010.

Sec. 18.23.050. PROTECTION OF PATIENT. Nothing in this chapter relieves a person of liability which he has incurred or may incur to a person as a result of furnishing health care to the patient.

Sec. 18.23.060. PARTIES BOUND BY REVIEW. When a review organization reviews matters under sec. 70(5)(H) of this chapter no party is bound by a ruling of the organization in a controversy, dispute or question unless he agrees in advance, either specifically or generally, to be bound by the ruling.

Sec. 18.23.070. DEFINITIONS. In this chapter, unless the context otherwise requires,

(1) "administrative staff" means the staff of a hospital or clinic;

(2) "health care" means professional services rendered by a health care provider or an employee of a health care provider, and services furnished by a sanatorium, rest home, nursing home, boarding home or other institution for the hospitalization or care of human beings;

(3) "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.-72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital;

(4) "professional service" means service rendered by a health care provider of the type he is licensed to render;

(5) "review organization" means a hospital governing body or a committee whose membership is limited to health care providers and administrative staff, except where otherwise provided for by state or federal law, and which is established by a hospital, by a clinic, by one or more state or local associations of health care providers, by an organization of health care providers from a particular area or medical institution, or by a professional standards review organization established under 42 U.S.C., sec. 1320(c)(1) et seq., to gather and revi information relating to the care and treatment of patients for the purposes of

(A) evaluating and improving the quality of health care rendered in the area or medical institution;

(B) reducing morbidity or mortality;

(C) obtaining and disseminating statistics and information relative to the treatment and prevention of diseases, illness and injuries;

(D) developing and publishing guidelines showing the norms of health care in the area or medical institution;

(E) developing and publishing guidelines designed to keep the cost of health care within reasonable bounds;

(F) reviewing the quality or cost of health care services provided to enrollees of health maintenance organizations;

(G) acting as a professional standards review organization under 42 U.S.C., sec. 1320(c)(1) et seq.;

(H) reviewing, ruling on, or advising on controversies, disputes or questions between

(i) a health insurance carrier or health maintenance organization and one or more of its insured or enrollees;

(ii) a professional licensing board, acting under its powers of discipline or license revocation or suspension, and a health care provider licensed by it when the matter is referred to a review organization by the professional licensing board;

(iii) a health care provider and his patients concerning diagnosis, treatment or care, or a charge or fee;

(iv) a health care provider and a health insurance carrier or health maintenance organization concerning a charge or fee for health care services provided to an insured or enrollee; or

(v) a health care provider or his patients and the federal or a state or local government, or an agency of the

federal or a state or local government;

(I) acting on the recommendation of a credential review committee or a grievance committee.

* Sec. 23. AS 21 is amended by adding a new chapter to read:

CHAPTER 88. HEALTH CARE PROVIDERS INSURANCE.

ARTICLE 1. PURPOSE.

Sec. 21.88.010. PURPOSE OF CHAPTER. It is the purpose of this chapter to provide a means of assuring all health care providers with continuous, affordable and adequate insurance against liability for medical negligence by concentrating all such insurance in one entity which can negotiate more successfully for insurance from casualty insurers licensed by this state and to distribute equitably the cost of the insurance among the health care providers insured.

ARTICLE 2. INDEMNITY CORPORATION.

Sec. 21.88.020. CORPORATION CREATED. There is created the Alaska Health Care Providers Indemnity Corporation which is a public corporation having a legal existence independent of and separate from the state. Obligations issued by the corporation do not constitute a debt liability or obligation of the state or a pledge of full faith and credit of the state.

Sec. 21.88.030. CORPORATION BOARD OF GOVERNORS. (a) The corporation shall exercise its powers through a board of governors which shall be appointed by the director as provided in (b) of this section.

(b) The appointments to the board of governors shall be Alaska residents as follows:

(1) one member of the Alaska State Medical Association appointed from a list of no less than three persons recommended by the governing board of that association;

(2) one member of the Alaska State Hospital Association

appointed from a list of no less than three persons recommended by the governing board of that association;

(3) ~~three~~ Two professionals in the insurance field;

(4) ~~two~~ Three persons who are not [attorneys,] health care providers, or [representatives] not affiliate with the insurance industry. adopted

(c) The term of office of each governor is three years, except that the director shall designate three initially appointed governors to serve for one year and two initially appointed governors to serve for two years.

(d) Upon the expiration of the term of a governor, the director shall appoint a successor who shall be from the same class described in (b) of this section as the governor whose term has expired.

(e) Upon a governor's early resignation, death or inability to serve, the director shall appoint a successor from the same class defined in (b) of this section as the terminating governor, who shall serve for the unexpired term.

(f) The director or his designee is not a voting member of the board of governors but shall be notified by the board of and have the right to attend and participate in all meetings and proceedings of the board.

(g) Each member of the board of governors shall be allowed compensation for services and reimbursement for reasonable expenses incurred in attending meetings of the board and transacting corporation business, ~~as set out in the plan of operation.~~ $100 a day & travel

Sec. 21.88.040. CORPORATION PLAN OF OPERATION. (a) Within 30 days after the effective date of this chapter, the board of governors shall prepare and submit to the director for approval a plan of operation which provides for the fair, reasonable and equitable administration of the affairs of the corporation and the discharge of the purposes

for which it is created. The plan and any amendments of it become effective upon the director's approval. If the board of governors has failed to submit a plan of operation, or if at any subsequent time the board of governors fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate a plan of operation or amendments which are necessary or advisable to effectuate the provisions of this chapter. Adoption of the plan is not subject to the Administrative Procedure Act (AS 44.62).

(b) The plan of operation shall

(1) establish the procedures by which all the powers and duties of the corporation specified in sec. 50 of this chapter shall be performed;

(2) establish procedures for handling assets and discharging liabilities of the corporation;

(3) establish regular places and times for meetings of the board of governors;

(4) establish procedures for records to be kept of all financial transactions of the corporation, its agents, and the board of governors;

(5) establish the amount and method of reimbursing and compensating members of the board of governors;

(6) establish procedures for awarding contracts to carry out the provisions of this chapter;

(7) establish the procedures for issuing contracts of insurance as provided in sec. 50 of this chapter and for the determination of rates;

(8) contain additional provisions necessary or proper for the execution of the powers and duties of the corporation.

Sec. 21.88.050. POWERS AND DUTIES OF THE CORPORATION. (a) The

corporation shall

(1) issue to all health care providers who pay the premiums for it a contract on an occurrence basis indemnifying the health care provider and his employees who are health care providers against loss by reason of liability and agreeing to tender on behalf of the health care provider and his employees who are health care providers a defense of the health care provider in a proceeding brought under AS 09.55.530 - 09.55.560; the limit of liability shall be no less than the minimum liability coverage required to be maintained as stated in AS 08.64.215 and AS 18.20.045; the contract shall cover the defense against but need not indemnify a claim for punitive damages; the contract shall cover claims against health care providers

(A) that arise out of professional services performed by the health care provider during the period for which the premium is paid; And at the option of the health care provider,"

Amended Blocks language

(B) that arise out of services performed by the health care provider after January 1, 1975 and are filed within three years from the date the services were performed but were not discovered by the health care provider when he chose to take this coverage;

(2) charge a premium for the protection provided by the contracts issued under (1) of this subsection which shall be determined by the board of governors in accordance with sec. 70 of this chapter and subject to the approval of the director;

(3) comply with or be subject to AS 21.06.090, 21.06.120, 21.06.140, 21.06.160, 21.06.250; AS 21.09.180, 21.09.190, 21.09.200, 21.09.250, 21.09.280; AS 21.12.020(b), (c), (d), and (e); and chs. 18, 23, 24, and 26 of this title; Except that reserves shall be made in accordance with 070 (4)(5)

(4) carry out the obligations of the contracts issued under

(1) of this subsection by defending all covered claims made against insured health care providers and by paying all liabilities which are finally adjudicated against the insured health care provider or which may in the opinion of the corporation reasonably be expected to be finally adjudicated against the health care provider to the extent of the contract obligation;

(5) provide coverage to health care providers for liability under AS 09.55.530 - 09.55.560 in excess of the minimum limits required for licensure as a health care provider, but limited to $1,000,000 for individual health care providers and $5,000,000 for hospitals, if there is a finding by the director that this coverage is unavailable at a reasonable cost and that this coverage can be made available at a reasonable cost through the corporation; if this paragraph is implemented, each health care provider obtaining excess coverage up to these amounts shall obtain it from the corporation, and the corporation ~~shall~~ May procure reinsurance for all the risks incurred by contracts issued under this paragraph from the private market.

(b) The corporation may contract for Management services for Ins Co.

(1) employ or retain persons, individual or corporate, to discharge its obligations and shall pay, by way of salary, wage, fee, or commission, reasonable compensation for those services; employees of the corporation are not considered state employees;

(2) provide coverage to health care providers for other hazards including malpractice liability insurance for other licensed health care providers employed by the physician or hospital if there is a finding by the director that this coverage is otherwise unavailable by reason of the operation of the corporation;

(3) borrow funds from the revolving loan fund established under sec. 110 of this chapter when necessary for the corporation to

maintain adequate reserves; loans from the fund shall be repaid within four years after the loan is made at an annual interest rate of seven percent and through prospective rate increases;

(4) negotiate and become a party to those contracts as are necessary to carry out the purposes of the corporation;

(5) sue or be sued in the name of the corporation;

(6) perform all other acts necessary and proper to effectuate the corporation.

Sec. 21.88.060. STATISTICS. The corporation shall collect, maintain and report information concerning claims against health care providers. All such information shall be on forms prescribed by the director and shall be sufficient to enable a proper determination of losses for rate making and to identify causes and sources of loss for loss control. No less often than annually the corporation shall report to the director, which report shall be kept available to the public, the number and amount of claims filed, reserved, paid, settled and adjudicated during the year, the premiums paid to, and the expenses incurred by the corporation during the year. The director may require that supplemental reports include the names of insured health care providers and the claimants; however, no reports which become publicly available may include the names of health care providers or claimants or information that will permit by inference the identity of specific health care providers or claimants. All information shall be made available to the appropriate licensing boards or agencies.

Sec. 21.88.070. RATES. Rates and rating plans used by the corporation for the policies issued shall be determined for each category of health care provider in accordance with all of the following:

(1) rates for physicians shall be set as a function of the physician's ~~XXXX~~ medical revenue; ~~Adjusted Business License Tax income attributable to the acts~~ as determined

Revised

(2) rates for hospitals shall be set as a function of the number of permanent beds in the hospital;

(3) a minimum rate may be set for each category of health care provider or discipline or classification within the license category;

(4) rates may not be excessive; rates are excessive if, after a period of time and with respect to an amount of gross premium which are actuarially credible, the premiums exceed losses incurred by the corporation, including losses paid, reserves for claims reported and unpaid, [reserves for claims incurred but not reported] and reasonable expenses for the operation of the corporation;

(5) rates may not be inadequate; rates are inadequate if, based on available actuarial data, the premiums to be paid by the health care providers are or may reasonably be expected to be insufficient to pay for losses incurred by the corporation, including claims paid, reserves for claims reported and unpaid, [reserves for claims incurred but not reported], and reasonable expenses for the operation of the corporation;

(6) rates shall be adjusted at least as often as annually;

(7) rates for any policy year shall be calculated to include the adjustment for actual experience of the corporation as developed for the preceding four policy years;

(8) in considering losses to be incurred, changes in the law and national, regional and local trends in medical negligence awards may be considered;

(9) income from investment of reserves shall be considered;

(10) disciplines and classifications within the license categories of health care providers shall be considered;

(11) individual risk underwriting factors shall be considered.

IN THE SENATE 2nd Draft BY THE COMMERCE COMMITTEE

CS FOR SENATE BILL NO. 651

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to health care; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 08.11.050 is amended by adding a new paragraph to read:

(19) provide investigative services to the boards established under chs. 20, 32, 36, 64, 68, 71, 72, 80, 84, and 86 of this title, for the purpose of assisting those boards in matters of professional discipline.

* Sec. 2. AS 08.20.010 is amended to read:

Sec. 08.20.010. CREATION AND MEMBERSHIP OF BOARD OF CHIROPRACTIC EXAMINERS. There is created the Board of Chiropractic Examiners consisting of <u>five</u> [THREE] members appointed by the governor.

* Sec. 3. AS 08.20.020 is amended to read:

Sec. 08.20.020. MEMBERS OF BOARD. <u>Three members</u> [EACH MEMBER] of the board shall be [A] licensed chiropractic <u>physicians who</u> [PHYSICIAN AND SHALL] have practiced chiropractic in this state not less than two years. <u>Two members of the board shall be persons with no direct financial interest in the health care industry.</u> Each member serves without pay but is entitled to per diem and travel expenses allowed by law.

* Sec. 4. AS 08.20 is amended by adding a new section to read:

Sec. 08.20.175. LIMITS OR CONDITIONS ON LICENSE; REPRIMAND. (a) In addition to action under sec. 170 of this chapter, upon a finding that [A] person of demonstrated problems of competence, experience, education or health the authority to practice chiropractic should be

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limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 5. AS 08.32 is amended by adding a new section to read:

Sec. 08.32.165. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 160 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education or health the authority to practice dental hygiene should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 6. AS 08.36.010 is amended to read:

Sec. 08.36.010. CREATION AND MEMBERSHIP OF BOARD. There is created the Board of Dental Examiners, referred to in this chapter as the board, consisting of <u>seven</u> [FIVE] members. <u>Five members</u> [EACH MEMBER] shall be [A CITIZEN OF THE UNITED STATES AND A] qualified resident <u>dentists</u> who <u>have</u> [HAS] been engaged in the practice of dentistry in the state for five years immediately preceding [his] appointment<u>, and two members shall be persons with no direct financial interest in the health care industry</u>.

* Sec. 7. AS 08.36.020 is amended to read:

Sec. 08.36.020. APPOINTMENT AND TERM OF SERVICE OF MEMBERS. Members of the board are appointed by the governor, subject to confirmation by the legislature in joint session [ASSEMBLED]. Each board member serves for a term of five years, and until his successor is

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appointed and qualified. The term begins on February 1. An appointment to a vacancy is for the unexpired term. [APPOINTMENTS SHALL BE MADE FROM A LIST OF NAMES RECOMMENDED BY THE ALASKA DENTAL SOCIETY. THE LIST SHALL BE SUPPLIED AT LEAST 30 DAYS BEFORE THE BEGINNING OF A TERM AND NOT MORE THAN 60 DAYS AFTER THE OCCURRENCE OF A VACANCY. THE LIST SHALL CONTAIN AT LEAST TWO RECOMMENDED NAMES FOR EACH APPOINTMENT. THE GOVERNOR SHALL MAKE THE APPOINTMENT WITHIN 30 DAYS AFTER RECEIVING THE LIST.]

* Sec. 8. AS 08.36 is amended by adding a new section to read:

Sec. 08.36.325. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 320 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health, the authority to practice dentistry should be limited or conditioned or the practitioner disciplined, the board may censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 9. AS 08.64.010 is amended to read:

Sec. 08.64.010. CREATION AND MEMBERSHIP OF STATE MEDICAL BOARD. The governor shall appoint a board of medical examiners, to be known as the State Medical Board, consisting of five licensed physicians, residing in as many separate Alaska judicial districts as possible <u>and two persons with no direct financial interest in the health care industry</u>. [EACH MEMBER SHALL BE CHOSEN FROM A PANEL OF THREE, FOR EACH VACANCY, SUBMITTED TO THE GOVERNOR BY THE ALASKA STATE MEDICAL ASSOCIATION.]

* Sec. 10. AS 08.64.090 is amended to read:

Sec. 08.64.090. QUORUM. <u>Four</u> [THREE] members of the board

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constitute a quorum for the transaction of all business properly before the board.

* Sec. 11. AS 08.64 is amended by adding new sections to read:

Sec. 08.64.215. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person shall maintain insurance issued by the Health Care Providers Indemnity Corporation against liability to patients for medical malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year.

(b) The director of insurance or his designee shall waive the requirement in (a) of this section for a person if that person furnishes satisfactory evidence of his having other insurance providing coverage in amounts not less than those specified in (a) of this section. No waiver granted under this subsection may extend beyond the normal expiration date of the person's insurance policy or January 1, 1977, whichever occurs first.

Sec. 08.64.325. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 330 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 12. AS 08.68.010 is amended to read:

Sec. 08.68.010. CREATION AND MEMBERSHIP OF BOARD OF NURSING. There is created a Board of Nursing, consisting of <u>seven</u> [FIVE] members appointed by the governor. One member shall be currently involved in

institutional nursing service, one member in community or public health nursing and two members in basic or continuing nursing education, [AND] one nurse at large, and two persons who have no direct financial interest in the health care industry.

* Sec. 13. AS 08.68.060 is amended to read:

Sec. 08.68.060. QUALIFICATIONS OF BOARD MEMBERS. The five members [EACH MEMBER] of the board who are nurses shall be [A CITIZEN OF THE UNITED STATES, A RESIDENT OF THE STATE, AND A] licensed professional nurses [NURSE] in the state, and [MEMBERS] shall have been actively engaged in nursing for not less than four years before appointment, two years of which were within the five years preceding appointment.

* Sec. 14. AS 08.68 is amended by adding a new section to read:

Sec. 08.68.275. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 270 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice nursing should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 15. AS 08.71.020 is amended to read:

Sec. 08.71.020. MEMBERSHIP OF BOARD; SOURCE OF APPOINTMENTS; TERM OF OFFICE. The board consists of seven [FIVE] persons appointed by the governor. [THE GOVERNOR SHALL APPOINT BOARD MEMBERS FROM A LIST OF QUALIFIED OPTICIANS PREPARED BY THE ASSOCIATION OF OPTICIANS IN THE STATE AND SUBMITTED AT LEAST 30 DAYS BEFORE JULY 1, 1973, AT LEAST 30 DAYS BEFORE THE EXPIRATION OF A TERM AND NOT MORE THAN 60 DAYS AFTER A VACANCY OCCURS IN AN UNEXPIRED TERM. THE LIST SHALL CONTAIN NOT LESS

THAN TWO RECOMMENDED CANDIDATES FOR EACH APPOINTMENT. THE GOVERNOR SHALL MAKE APPOINTMENTS WITHIN 30 DAYS AFTER RECEIVING THE LIST.] The term of office of each member is three years. [HOWEVER, OF THE FIRST MEMBERS OF THE BOARD, ONE SHALL BE APPOINTED FOR A ONE-YEAR TERM, TWO FOR TWO-YEAR TERMS, AND TWO FOR THREE-YEAR TERMS.] Vacancies on the board shall be filled for the unexpired term in the same manner as original appointment.

* Sec. 16. AS 08.71.030 is amended to read:

Sec. 08.71.030. QUALIFICATIONS OF BOARD MEMBERS. Five [...] board members [MEMBER] shall be [A] licensed, practicing dispensing opticians [OPTICIAN] residing in the state. Two shall be persons with no direct financial interest in the health care industry.

* Sec. 17. AS 08.71 is amended by adding a new section to read:

Sec. 08.71.175. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 170 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice as a dispensing optician under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 18. AS 08.72.020 is amended to read:

Sec. 08.72.020. MEMBERSHIP OF BOARD AND TERMS OF OFFICE. The board consists of five [THREE] persons, appointed by the governor. The term of each member is three years. [ONE MEMBER ONLY IS APPOINTED EACH YEAR, EXCEPT WHEN VACANCIES FOR UNEXPIRED TERMS ARE FILLED.]

* Sec. 19. AS 08.72.040 is repealed and re-enacted to read:

Sec. 08.72.040. QUALIFICATIONS. Three board members shall be licensed, practicing optometrists who have been residents for at least three years. Two shall be persons who have no direct financial interest in the health care industry.

* Sec. 20. AS 08.72 is amended by adding a new section to read:

Sec. 08.72.255. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under secs. 240 and 250 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice optometry under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 21. AS 08.80.010 is amended to read:

Sec. 08.80.010. CREATION AND MEMBERSHIP OF BOARD OF PHARMACY. There is created the Board of Pharmacy, composed of <u>seven</u> [FIVE] members <u>five</u> [EACH] of whom shall be <u>pharmacists</u> [A PHARMACIST] licensed in the state who has been actively engaged in the practice of pharmacy in the state for a period of three years immediately preceding his appointment <u>Two shall be persons with no direct financial interest in the health care industry.</u> Whenever possible, the board shall include at least one member from each judicial district.

* Sec. 22. AS 80.80 is amended by adding a new section to read:

Sec. 08.80.265. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 260 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice pharmacy under this

chapter should be limited or conditioned or the practitioner disciplined the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 23. AS 08.84 is amended by adding a new section to read:

Sec 08.84.185. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 180 of this chapter, upon a finding that by reason of demonstrated problems of competence, experience, education or health the authority to practice physical therapy should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 24. AS 08.86.010 is amended to read:

Sec. 08.86.010. CREATION AND MEMBERSHIP OF BOARD. There is created a Board of Psychologist and Psychological Associate Examiners. It consists of three licensed psychologists, and two persons who have no direct financial interest in the health care industry.

* Sec. 25. AS 08.86 is amended by adding a new section to read:

Sec. 08.86.220. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) Upon a finding that by reason of demonstrated problems of competence, experience, education, or health the authority to practice psychology or as a phsychological associate under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by time, specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 26. AS 09.55 is amended by adding new sections to read:

Sec. 09.55.535. MANDATORY ARBITRATION. (a) It is the purpose of these arbitration provisions to establish a system that will provide incentives to settle malpractice disputes without prolonged litigation and that will provide a method by which parties to a medical malpractice claim can obtain a prompt determination of its merits, and the amount of damages, if any, that should be allowed.

(b) Upon the filing of any malpractice claim against a physician or hospital, the claim shall be submitted to an arbitration board; ~~provided,~~ however, ~~that~~ submission to an arbitration board may not be required if all parties object to arbitration or if the parties have agreed to follow the procedures prescribed in sec. 536 of this chapter.

(c) The arbitration board shall consist of three arbitrators; one arbitrator designated by the plaintiff [redacted], one arbitrator designated by the defendant [redacted], and a third arbitrator designated by mutual agreement who shall serve as chairman of the board. If the parties cannot agree on the third person, the court will provide a list of three or more persons who might serve as chairman of the arbitration board, which shall be furnished by the attorney general. Plaintiff or plaintiffs together and defendant and defendants together may each strike one or more names from the list, so after each side has done so, at least one name remains on the list, providing a basis for the final selection by the court.

(d) The attorney general shall prepare a list of panelists consisting of lawyers or other persons qualified to serve as chairmen of arbitration boards. They shall be selected on basis of their technical expertise, judicial temperament, and capability of impartially acting

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on malpractice claims. The attorney general shall submit a list of at least three names of panelists whenever requested to do so by the court along with detailed biographical information on each panelist.

(e) Each member of the board shall receive reasonable compensation based on the extent and duration of services rendered ~~and paid in equal proportion by the parties in interest. In a claim accompanied by an affidavit stating that a party cannot afford the cost of arbitration, that party's share of the cost of arbitration costs shall be borne by the court, and~~ by the court. The court will also pay for the costs of experts required by the BOARD. If all parties agree in advance to binding arbitration, then the cost of arbitration shall be borne by the court.

(f) The provisions of the Uniform Arbitration Act, AS 09.43.010 - 09.43.180, apply to arbitrations under this section insofar as they are applicable and in accordance with any rules of court which may be adopted.

(g) If the decision of the arbitration board is not accepted by all parties, the decision of the arbitration board, including its conclusions as to the merits of the claim and appropriate damages, together with any dissenting opinions, shall be admissible in evidence at trial upon the offer of any party, if the court conducts a review of the arbitration decision and any other relevant information submitted by the parties and concludes that:

(1) the findings of fact by the arbitration board were not clearly erroneous;

(2) the decision is in accordance with applicable law;

(3) the procedures required for conducting the hearing and rendering the decision were followed fairly and properly without prejudice to any party;

(4) any party who has not offered the arbitration decision in evidence may subpoena any member ~~or members~~ of the arbitration board

for purposes of cross-examination.

Sec. 09.55.536. VOLUNTARY ARBITRATION. (a) A patient and any health care provider may execute an agreement to submit to arbitration any dispute, controversy, or issue arising out of care of treatment by the health care provider during the period that the agreement is in force or that has already arisen between the parties.

(b) An agreement to arbitrate executed before care of treatment is provided between a patient and health care provider shall clearly provide that execution of the agreement by the patient is not a prerequisite to receiving care or treatment, and this provision shall be explained orally to the patient before he is asked to sign. If this subsection is not complied with by the health care provider, the agreement to arbitrate is void. The form to be used shall be approved in advance by the director of insurance to assure it fairly informs the patient and properly protects his interests.

(c) Each admission to a hospital shall be treated as separate and distinct for the purposes of an agreement to arbitrate, but a person receiving outpatient care from a hospital or clinic or a member of a health maintenance organization may execute an agreement with the hospital which provides for continuation of the agreement for a continuing program of treatment or during continued membership.

(d) Arbitration shall take place under the same procedures prescribed for mandatory arbitration under sec. 536 of this chapter unless the parties agree otherwise in accordance with general guidelines promulgated as regulations by the director of insurance to assure fairness to the parties.

(e) ~~The~~ Reasonable ~~costs of voluntary binding arbitration shall be borne by the parties~~ compensation based on the extent and duration of services rendered and paid will be paid to members of the arbitration board by the court as well as cost of experts required by the court.

* Sec. 27. AS 09.55.540 is amended to read:

Sec. 09.55.540. BURDEN OF PROOF. (a) In a malpractice action based on the negligence or wilful misconduct of a health care provider [PHYSICIAN LICENSED UNDER AS 08.64, OR A DENTIST LICENSED UNDER AS 08.-36], the plaintiff has [SHALL HAVE] the burden of proving by a preponderance of the evidence

(1) the degree of knowledge or skill possessed or the degree of care ordinarily exercised under the circumstances, at the time of the act complained of, by health care providers in the field or specialty in which the defendant is practicing [BY PHYSICIANS OR DENTISTS PRACTICING THE SAME SPECIALTY IN SIMILAR COMMUNITIES TO THAT IN WHICH THE DEFENDANT PRACTICES];

(2) that the defendant either lacked this degree of knowledge or skill or failed to exercise this degree of c[illegible]e; and

(3) that as a proximate result of this lack of knowledge or skill or the failure to exercise this degree of care the plaintiff suffered injuries that would not otherwise have been incurred.

(b) In malpractice actions there is [SHALL BE] no presumption of negligence on the part of the defendant.

* Sec. 28. AS 09.55 is amended by adding new sections to read:

Sec. 09.55.546. AD[illegible]NCE PAYMENTS. In an action to recover damages under secs. 530 - 540 of this chapter, no advance payment made by the defendant health care provider or his professional liability insurer to or on behalf of the plaintiff may be admissible as evidence or may be construed as an admission of liability for injuries or damages suffered by the plaintiff; however, a final award in favor of the plaintiff shall be reduced to the extent of any advance payment. The advance payment shall inure to the exclusive benefit of the defendant or the insurer making the payment.

Sec. 09.55.547. AD DAMNUM. In a cause of action against a health

care provider for malpractice, the complaint or any other pleadings may not contain an ad damnum clause or monetary amount claimed against the defendant health care provider, except as necessary for jurisdictional purposes.

Sec. 09.55.548. AWARDS, COLLATERAL SOURCE, PROVIDER'S LIABILITY. (a) Damages shall be awarded in accordance with principles of the common law. The fact finder in a malpractice action shall render an award as to damages by category of loss. The court may enter a judgment that future damages be paid in whole or in part by periodic payments rather than by a lump-sum payment; the judgment shall include, if necessary, other provisions to assure that funds will be available as periodic payments become due. In this subsection, future damages includes damages for future medical treatment, care or custody, loss of future earnings, or loss of bodily function of the claimant.

(b) Except when the collateral source is a federal program which by law must seek subrogation and except death benefits paid under life insurance, a claimant may only recover damages from the defendant which exceed amounts received by the claimant as compensation for his injuries from collateral sources, whether private, group or governmental, and whether contributory or noncontributory. Evidence of collateral sources, other than a federal program which must by law seek subrogation and the death benefit paid under life insurance, is admissible after the fact finder has rendered an award, but the court shall also take into account the value of claimant's rights to coverage exhausted or depleted by payment of these collateral benefits. It may do so by adding back a reasonable estimate of their probable value, or by earmarking and holding for possible periodic payment under (a) of this section that amount of the award that would otherwise have been deducted, to see if the impairment of claimant's rights actually takes place in the future.

* Sec. 29. AS 09.55.550 is amended to read:

Sec. 09.55.550. JURY INSTRUCTIONS. In health care [MEDICAL] malpractice actions the jury shall be instructed that the plaintiff has the burden of proving [, BY A PREPONDERANCE OF THE EVIDENCE,] the health care provider's negligence or wilful misconduct in accordance with the standard of proof specified in sec. 540 of this chapter [OF THE PHYSICIAN OR DENTIST]. The jury shall be further instructed that injury alone does not raise a presumption of the health care provider's [PHYSICIAN'S OR DENTIST'S] negligence or misconduct.

* Sec. 30. AS 09.55 is amended by adding new sections to read:

Sec. 09.55.556. INFORMED CONSENT. (a) A health care provider is liable for failure to obtain the informed consent of a patient if the claimant establishes by a preponderance of the evidence that the provider has failed to inform the patient of the common risks and reasonable alternatives to the proposed treatment or procedure, and that but for the failure the claimant would not have consented to the proposed treatment or procedure.

(b) It is a defense to any action for health care malpractice based upon an alleged failure to obtain informed consent that

(1) the risk not disclosed is too commonly known or is too remote to require disclosure;

(2) the patient stated to the health care provider that he would undergo the treatment or procedure regardless of the risk involved or that he did not want to be informed of the matters to which he would be entitled to be informed;

(3) under the circumstances consent by or on behalf of the patient was not possible; or

(4) the health care provider after considering all of the attendant facts and circumstances used reasonable discretion as to the

manner and extent that the alternatives or risks were disclosed to the patient because he reasonably believed that a full disclosure would have a substantially adverse effect on the patient's condition.

Sec. 09.55.560. DEFINITIONS. In secs. 530 - 560 of this chapter "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital.

* Sec. 31. AS 18.20 is amended by adding a new section to read:

Sec. 18.20.045. INSURANCE REQUIRED. (a) Every hospital, as a condition of licensure, shall maintain and submit to the department evidence of insurance against liability to inpatients and outpatients for malpractice issued by the Health Care Providers Indemnity Corporation, in amounts of not less than $200,000 per occurrence, and an aggregate liability per year of $1,000,000 minimum, and an additional $20,000 for each bed over 50.

(b) The director of insurance or his designee shall waive the requirement in (a) of this section for a hospital if the hospital furnishes satisfactory evidence of having other insurance providing coverage in amounts not less than those specified in (a) of this section. No waiver granted under this subsection may extend beyond the normal expiration date of the hospital's insurance policy or January 1, 1977, whichever occurs first.

* Sec. 32. AS 18 is amended by adding a new chapter to read:

CHAPTER 23. HEALTH CARE SERVICES INFORMATION.

Sec. 18.23.010. LIMITATION ON LIABILITY FOR PERSONS PROVIDING INFORMATION TO REVIEW ORGANIZATION. (a) No person providing information to a review organization is subject to action for damages or other relief by reason of having furnished that information, unless the information is false and the person providing the information knew or had reason to know the information was false.

(b) No privilege of confidentiality arising from a physician-patient relationship may be invoked to withhold pertinent information from review by a review organization.

Sec. 18.23.020. LIMITATION ON LIABILITY FOR MEMBERS OF REVIEW ORGANIZATIONS. No person who is a member or employee of, or who acts in an advisory capacity to, or who furnishes counsel or services to a review organization is liable for damages or other relief in an action brought by another whose activities have been or are being scrutinized or reviewed by a review organization, by reason of the performance of a duty, function or activity of the review organization, unless the performance of the duty, function or activity was motivated by malice toward the affected person. No person is liable for damages or other relief in an action by reason of his performance of a duty, function, or activity as a member of a review organization or by reason of a recommendation or action of the review organization when the person acts in the reasonable belief that the action or recommendation is warranted by facts known to the person or to the review organization after reasonable efforts to ascertain the facts upon which the review organization's action or recommendation is made.

Sec. 18.23.030. CONFIDENTIALITY OF RECORDS OF REVIEW ORGANIZATION (a) Except as provided in (b) of this section, all data and information acquired by a review organization, in the exercise of its duties and

functions, shall be held in confidence and may not be disclosed to anyone except to the extent necessary to carry out the purposes of the review organization, and is not subject to subpoena or discovery. Except as provided in (b) of this section, no person described in sec. 20 of this chapter may disclose what transpired at a meeting of a review organization except to the extent necessary to carry out the purposes of a review organization, and the proceedings and records of a review organization are not subject to discovery or introduction into evidence in a civil action against a health care provider arising out of the matter which is the subject of consideration by the review organization. Information, documents, or records otherwise available from original sources are not immune from discovery or use in a civil action merely because they were presented during proceedings of a review organization, nor may a person who testified before a review organization or who is a member of it be prevented from testifying as to matters within his knowledge, but a witness may not be asked about his testimony before a review organization or opinions formed by him as a result of its hearings, except as provided in (b) of this section.

(b) Testimony, documents, proceedings, records, and other evidence adduced before a review organization that are otherwise inaccessible under this section may be obtained by a health care provider who claims that denial is unreasonable, or may be obtained under subpoena or discovery proceedings brought by a plaintiff who claims that information provided to a review organization was false and claims that the person providing the information knew or had reason to know the information was false.

(c) Nothing in this chapter prevents a person whose conduct or competence has been reviewed under this chapter from obtaining, for the purpose of appellate review of the action of the review organization,

any testimony, documents, proceedings, records and other evidence adduced before the review organization.

Sec. 18.23.040. PENALTY FOR VIOLATION. Other than as authorized by sec. 30 of this chapter, a disclosure of data and information acquired by a review committee or of what transpired at a review meeting is a misdemeanor and punishable under AS 11.05.010.

Sec. 18.23.050. PROTECTION OF PATIENT. Nothing in this chapter relieves a person of liability which he has incurred or may incur to a person as a result of furnishing health care to the patient.

Sec. 18.23.060. PARTIES BOUND BY REVIEW. When a review organization reviews matters under sec. 70(5)(H) of this chapter no party is bound by a ruling of the organization in a controversy, dispute or question unless he agrees in advance, either specifically or generally, to be bound by the ruling.

Sec. 18.23.070. DEFINITIONS. In this chapter, unless the context otherwise requires,

(1) "administrative staff" means the staff of a hospital or clinic;

(2) "health care" means professional services rendered by a health care provider or an employee of a health care provider, and services furnished by a sanatorium, rest home, nursing home, boarding home or other institution for the hospitalization or care of human beings;

(3) "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a

psychologist and a psychological associate li ensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital;

(4) "professional service" means service rendered by a health care provider of the type he is licensed to render;

(5) "review organization" means a hospital governing body or a committee whose membership is limited to health care providers and administrative staff, except where otherwise provided for by state or federal law, and which is established by a hospital, by a clinic, by one or more state or local associations of health care providers, by an organization of health care providers from a particular area or medical institution, or by a professional standards review organization established under 42 U.S.C., sec. 1320c-1 et seq., to gather and review information relating to the care and treatment of patients for the purposes of

(A) evaluating and improving the quality of health care rendered in the area or medical institution;

(B) reducing morbidity or mortality;

(C) obtaining and disseminating statistics and information relative to the treatment and prevention of diseases, illness and injuries;

(D) developing and publishing guidelines showing the norms of health care in the area or medical institution;

(E) developing and publishing guidelines designed to keep the cost of health care within reasonable bounds;

(F) reviewing the quality or cost of health care services provided to enrollees of health maintenance organizations;

(G) acting as a professional standards review organization under 42 U.S.C., sec. 1320c-1 et seq.;

(H) reviewing, ruling on, or advising on controversies, disputes or questions between

(i) a health insurance carrier or health maintenance organization and one or more of its insured or enrollees;

(ii) a professional licensing board, acting under its powers of discipline or license revocation or suspension, and a health care provider licensed by it when the matter is referred to a review organization by the professional licensing board;

(iii) a health care provider and his patients concerning diagnosis, treatment or care, or a charge or fee;

(iv) a health care provider and a health insurance carrier or health maintenance organization concerning a charge or fee for health care services provided to an insured or enrollee; or

(v) a health care provider or his patients and the federal or a state or local government, or an agency of the federal or a state or local government;

(I) acting on the recommendation of a credential review committee or a grievance committee.

* Sec. 33. AS 21 is amended by adding a new chapter to read:

CHAPTER 88. HEALTH CARE PROVIDERS INSURANCE.

ARTICLE 1. PURPOSE.

Sec. 21.88.010. PURPOSE OF CHAPTER. It is the purpose of this chapter to provide a means of furnishing health care providers with adequate insurance against liability for medical negligence by concentrating all such insurance in one entity which can negotiate more successfully for insurance from casualty insurers and to distribute

equitably the true cost of the insurance among the health care providers insured.

ARTICLE 2. INDEMNITY CORPORATION.

Sec. 21.88.020. CORPORATION CREATED. There is created the Alaska Health Care Providers Indemnity Corporation which is a public corporation having a legal existence independent of and separate from the state. Obligations issued by the corporation do not constitute a debt, liability or obligation of the state or a pledge of full faith and credit of the state.

Sec. 21.88.030. CORPORATION BOARD OF GOVERNORS. (a) The corporation shall exercise its powers through a board of governors which shall be appointed by the governor of the state and confirmed by the legislature as provided in (b) of this section.

(b) The appointments to the board of governors shall be Alaska residents as follows:

(1) two physicians licensed in the state; one of the physicians shall be engaged in group practice in a clinic of six or more physicians;

(2) one person employed by a hospital or on the board of directors of a hospital;

(3) two professionals in the insurance field;

(4) two persons who are not health care providers or financially interested in the field of health care, attorneys, or representatives of the insurance industry.

(c) The term of office of each governor is three years, except that the director shall designate two initially appointed governors to serve for one year and two initially appointed governors to serve for two years.

(d) Upon the expiration of the term of a governor, the director

shall appoint a successor who shall be from the same class described in (b) of this section as the governor whose term has expired.

(e) Upon a governor's early resignation, death or inability to serve, the director shall appoint a successor from the same class defined in (b) of this section as the terminating governor, who shall serve for the unexpired term.

(f) The director or his designee is not a voting member of the board of governors but shall be notified by the board of and have the right to attend and participate in all meetings and proceedings of the board.

(g) Each member of the board of governors shall be allowed compensation for services and reimbursement for reasonable expenses incurred in attending meetings of the board and transacting corporation business, as set out in the plan of operation.

Sec. 21.88.040. CORPORATION PLAN OF OPERATION. (a) Within 30 days after the effective date of this chapter, the board of governors shall prepare and submit to the director for approval a plan of operation which provides for the fair, reasonable and equitable administration of the affairs of the corporation and the discharge of the purposes for which it is created. The plan and any amendments of it become effective upon the director's approval. If the board of governors fails to submit a plan of operation, or if at a subsequent time the board of governors fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate a plan of operation or amendments which are necessary or advisable to effectuate the provisions of this chapter. Adoption of the plan is not subject to the Administrative Procedure Act (AS 44.62).

(b) The plan of operation shall

(1) establish the procedures by which all the powers and

duties of the corporation specified in sec. 50 of this chapter shall be performed;

(2) establish procedures for handling assets and discharging liabilities of the corporation;

(3) establish regular places and times for meetings of the board of governors;

(4) establish procedures for records to be kept of all financial transactions of the corporation, its agents, and the board of governors;

(5) establish the amount and method of reimbursing and compensating members of the board of governors;

(6) establish the procedures for awarding contracts to indemnify or defend or to provide other services and to compensate the indemnitors or vendors;

(7) establish the procedures for issuing contracts of insurance as provided in sec. 50 of this chapter and for the determination of rates;

(8) contain additional provisions necessary or proper for the execution of the powers and duties of the corporation.

Sec. 21.88.050. POWERS AND DUTIES OF THE CORPORATION. (a) The corporation shall

(1) in the form approved by the director, issue to all health care providers who pay the premiums for it a contract indemnifying the health care provider and his employees who are health care providers against loss by reason of liability for professional services and agreeing to tender on behalf of the health care provider and his employees who are health care providers a defense in a proceeding brought under AS 09.55.530 - 09.55.560; the limit of liability shall be no less than the minimum liability coverage requirements to be main-

tained under AS 08.64.215 and AS 18.20.045; the contract shall cover the defense against but need not indemnify a claim for punitive damages; at the option of the health care provider and for an additional premium the contract may cover claims against the health care provider that arise out of professional services performed by the health care provider after December 31, 1974 and are filed within three years after those services were performed, except that coverage will not be provided for a claim already filed or of which the health care provider had or reasonably should have had notice at the time the retroactive insurance was purchased;

(2) charge a premium for the protection provided by the contracts issued under (1) of this subsection which shall be determined by the board of governors in accordance with sec. 80 of this chapter and subject to the approval of the director;

(3) negotiate for and procure reinsurance from a casualty insurer or reinsurer for all of its liability incurred by contracts issued under (1) of this subsection; the corporation may not incur or retain under those contracts liability which is not reinsured as provided in this paragraph; if, after the exercise of due diligence, no reinsurance can be procured at reasonable rates from a casualty insurer or reinsurer, the corporation through the board of governors, shall so certify to the director; reinsurance shall then be provided by the Health Care Joint Underwriting Association as provided in sec. 110 et seq. of this chapter;

(4) comply with or be subject to AS 21.06.090; 21.06.120; 21.06.140; 21.06.160; 21.06.250; AS 21.09.180; 21.09.190; 21.09.200; 21.09.250; 21.09.280; AS 21.12.020(b), (c), (d), and (e); and chs. 18, 21, 24, and 36 of this title;

(5) carry out the obligations of the contracts issued under

(1) of this subsection by defending all covered claims made against insured health care providers and by paying all liabilities which are finally adjudicated against the insured health care provider or which may in the opinion of the corporation reasonably be expected to be finally adjudicated against the health care provider to the extent of the contract obligation;

(6) provide coverage to health care providers for liability in excess of the minimum limits required for licensure as a health care provider, but limited to $1,000,000 for individual health care providers and $5,000,000 for hospitals, if there is a finding by the director that this coverage is unavailable at a reasonable cost and that this coverage can be made available at a reasonable cost through the corporation; if this paragraph is implemented, then each health care provider obtaining excess coverage up to these amounts shall obtain it from the corporation.

(b) The corporation may

(1) in the form approved by the director, issue contracts of professional liability insurance to chiropractors licensed under AS 08.20, dental hygienists licensed under AS 08.32, dentists licensed under AS 08.36, nurses licensed under AS 08.68, dispensing opticians licensed under AS 08.71, optometrists licensed under AS 08.72, pharmacists licensed under AS 08.80, physical therapists licensed under AS 08.[illegible], and pyschologists and psychological associates licensed under AS 08.86;

(2) employ or retain persons, individual or corporate, to discharge its obligations and pay reasonable compensation for those services; employees of the corporation are not considered state employees;

(3) provide coverage to health care providers for other hazards where there is a finding by the director that this coverage is

otherwise unavailable by reason of the operation of the corporation;

(4) borrow or advance funds necessary to effectuate the purposes of the corporation;

(5) negotiate and become a party to those contracts as are necessary to carry out the purposes of the corporation;

(6) sue or be sued in the name of the corporation;

(7) perform all other acts necessary and proper to effectuate the corporation.

Sec. 21.88.060. PREMIUM TAX. The corporation shall pay a premium tax in the amount of one and one-half per cent of the total direct premium income received by the corporation during the year ending on the preceding December 31, after deducting the applicable cancellations, returned premium, the unabsorbed portion of any deposit premiums, all policy dividends, unabsorbed premiums refunded to policyholders, refunds, savings, savings coupons and other similar returns paid or credited to policyholders with respect to their policies. The tax shall be paid to the director annually before April 1 of each year.

Sec. 21.88.070. STATISTICS. The corporation shall collect, maintain and report information concerning claims against health care providers. The information shall be on forms prescribed by the director, and shall be sufficient to enable a proper determination of losses for rate making and to identify causes and sources of loss for loss control. At least annually the corporation shall report to the director the number and amount of claims filed, reserved, paid, settled and adjudicated during the year, the premiums paid to and the expenses incurred by the corporation during the year. This report shall be available to the public. The director may require that supplemental reports include the names of insured health care providers and the claimants; however, no reports which become publicly available may

include the names of health care providers or claimants or information that will permit by inference the identity of specific health care

providers or claimants. All statistics shall be made available to the appropriate licensing board or agency.

Sec. 21.88.080. RATES. The rates and rating plans used by the corporation for the policies issued shall be determined by license category of health care providers in accordance with all of the following:

(1) rates may not be excessive; rates are excessive if, after a period of time and with respect to an amount of gross premium which are actuarially credible, the premiums exceed losses incurred by the corporation, including losses paid, reserves for claims reported and unpaid, reserves for claims incurred during the policy period and not reported, and reasonable expenses for the operation of the corporation;

(2) rates shall not be inadequate; rates are inadequate if, based on available actuarial data, the premiums to be paid by the health care providers are or may reasonably be expected to be insufficient to pay for losses incurred by the corporation, including claims paid, reserves for claims reported and unpaid, reserves for claims incurred during the policy period and not reported; and reasonable expenses for the operation of the corporation;

(3) ~~rate shall~~ may not be unfairly discriminatory;

(4) rates shall be adjusted annually;

(5) rates for any policy year shall be calculated to include the adjustment for actual experience of the corporation [redacted];

(6) in considering losses to be incurred, changes in the law, national, regional or local trends in medical negligence awards, and other relevant factors may be considered;

(7) income from the investment of reserves shall be considered;

(8) individual risk underwriting factors shall be considered.

Sec. 21.88.090. REQUIRED INSURANCE; CANCELLATION. The corporation shall provide insurance to all health care providers otherwise eligible for licensure under AS 08.64 and AS 18.20. The corporation may provide for installment payment of premiums in which event each installment is due by the date specified. The corporation may cancel any of its policies in the event of nonpayment of any premium or installment on a premium, or other charge, by mailing or delivering to the insured at the address shown on the policy and to the agency of the state issuing the insured's license written notice stating when, not less than 10 days after notice is received by the insured, the cancellation is effective.

ARTICLE 3. JOINT UNDERWRITING ASSOCIATION.

Sec. 21.88.110. ASSOCIATION CREATED. (a) The Health Care Providers Joint Underwriting Association is created consisting of all insured

(1) ~~licensed~~ health care service corporations as defined in AS 21.87.330;

(2) disability insurers as defined in AS 21.12.050;

(3) property insurers as defined in AS 21.12.060; and

(4) casualty insurers as defined in AS 21.12.070.

(b) Every insurer described in (a) of this section shall be a member of the association and shall remain a member as a condition of its authority to continue to transact that kind of business in this state; except that any disability insurer may elect to pay any tax or assessments due without otherwise participating as a member.

(c) The association shall commence operation upon a finding by the director, after public hearing, that after the exercise of due diligence no reinsurance could be procured at reasonable rates by the corporation from a casualty insurer or reinsurer. After the association has commenced operation, if the director determines, after public hearing, that health care malpractice insurance is available through insurers licensed

in this state with respect to which he has previously made the former finding, the association shall cease its underwriting operations. At any time, after notice and hearing, the director may, upon a finding that it is no longer needed, terminate the operation of the association.

Sec. 21.88.120. PURPOSE. The purpose of the association is to provide a market for medical malpractice insurance to the corporation on a self-supporting basis without subsidy from association members.

Sec. 21.88.130. ASSOCIATION BOARD OF DIRECTORS; TERM. The association shall be governed by a board of directors appointed by the governor of the state and consisting of two representatives of domestic casualty and property insurers, one representative of admitted disability insurers, one representative of health care service corporations, one representative of foreign casualty and property insurers, and two persons from the public. Members of the board of directors serve three-year terms.

Sec. 21.88.140. ASSOCIATION PLAN OF OPERATION. (a) Within 30 days after the association's creation the board of directors shall prepare and submit to the director for his approval a plan of operation which provides for the fair, reasonable and equitable administration of the affairs of the association and the discharge of the purposes for which it is created. The plan and any amendments of it become effective upon the director's approval. If the board of directors has failed to submit a plan of operation, or if at any subsequent time the board of directors fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate a plan of operation or amendments which are necessary or advisable to effectuate the provisions of this chapter. Adoption of the plan is not subject to the Administrative Procedure Act (AS 44.62).

(b) The plan of operation shall

(1) establish the procedures for carrying out the powers and duties of the association specified in sec. 150 of this chapter;

(2) establish procedures for handling assets and discharging liabilities of the association;

(3) establish regular places and times for meetings of the board of directors;

(4) establish procedures for records to be kept of all financial transactions of the association, its agents, and the board of directors;

(5) establish the amount and method of reimbursing members of the board of directors;

(6) establish the procedures for awarding contracts to indemnify or defend or to provide other services and to compensate the indemnitors or vendors;

(7) establish the procedures for issuing contracts of insurance as provided in sec. 150 of this chapter and for the determination of rates;

(8) contain additional provisions necessary or proper for the execution of the powers and duties of the association.

Sec. 21.88.150. POWERS AND DUTIES OF THE ASSOCIATION. (a) The association shall

(1) provide reinsurance to the corporation covering contracts issued by the corporation indemnifying health care providers and their employees who are health care providers against loss by reason of liability for professional services and agreeing to tender on behalf of the health care providers and their employees who are health care providers a defense in an action brought under AS 09.55.530 - 09.55.560; the limit of liability shall be no less than the minimum liability required to be indemnified as provided in AS 08.64.315 and AS 18.20.045,

and the coverage shall be the same as that which the Health Care Providers Indemnity Corporation is required to provide under sec. 50 of this chapter;

(2) charge a premium for the protection provided by the contracts issued under sec. 50 of this chapter which shall be determined by the board of directors in accordance with sec. 80 of this chapter and subject to the approval of the director;

(3) comply with or be subject to AS 21.06.090; 21.06.120; 21.06.140; 21.06.160; 21.06.250; AS 21.09.180; 21.09.200; 21.09.250; 21.09.280; AS 21.12.020(b), (c), (d), and (e); and chs. 18, 21, 24, and 36 of this title;

(4) carry out the obligations of the contracts issued under sec. 50 of this chapter by defending all covered claims made against insured health care providers and paying all liabilities which are finally adjudicated against the insured health care provider or which may in the opinion of the association reasonably be expected to be finally adjudicated against the health care provider to the extent of the contract obligation.

(b) The association may

(1) employ or retain persons, individual or corporate, to discharge its obligations and pay reasonable compensation for those services;

(2) provide reinsurance to the corporation for coverage to health care providers for other hazards where there is a finding by the director that this coverage is otherwise unavailable by reason of the operation of the corporation;

(3) provide reinsurance to the corporation for coverage to health care providers for liability under AS 09.55.530 - 09.55.560 in excess of the minimum limits required for licensure as a health care

unavailable at a reasonable cost and that this coverage can be made available at a reasonable cost through the corporation;

(4) provide reinsurance to the corporation for coverage for liability under AS 09.55.530 - 09.55.560 to chiropractors licensed und AS 08.20, dental hygienists licensed under AS 08.32, dentists licensed under AS 08.36, nurses licensed under AS 08.68, dispensing opticians licensed under AS 08.71, optometrists licensed under AS 08.72, pharmacists licensed under AS 08.80, physical therapists licensed under AS 08.84, and psychologists and psychological associates licensed unde AS 08.86;

(5) borrow or advance funds necessary to effectuate the purposes of this association;

(6) negotiate and become a party to those contracts which a necessary to carry out the purposes of the association;

(7) sue or be sued in the name of the association;

(8) cede or assume reinsurance;

(9) perform all other acts necessary and proper to effectuat the association.

Sec. 21.88.160. RATES AND RATING PLANS. The rates and rating plans shall be determined as provided in sec. 80 of this chapter, except that allowance may not be made for profit to an indemnifying carrier or for income from investment of member-contributed funds; and provided that reserves for claims incurred during the policy period and reasonably expected to be reported after three years after the incident may be included on a different basis due to the additional financial flexibility provided by the association.

Sec. 21.88.170. ASSESSMENT. If sufficient funds are not availabl for the sound financial operation of the association, all members shall contribute to the financial requirements of the association by paying t

the association an assessment to be determined by the board of governors of the association, these assessments to be prorated among all members in proportion to their direct written premiums or revenues in this state in the insurance lines the writing of which require membership in the association, in the two years ending on the preceding December 31, after deducting the applicable cancellations, returned premium, the unabsorbed portion of any deposit premium, all policy dividends, unabsorbed premiums refunded to policyholders, refunds, savings, savings coupons and other similar returns paid or credited to policyholders with respect to their policies. Any assessment under this section is a tax obligation in addition to taxes required under AS 21.09.210 and notwithstanding the provisions of AS 21.09.210(e). ~~Insume~~

Sec. 21.88.180. RATE ADJUSTMENT. (a) If in any year an assessment is made under sec. 170 of this chapter, rates for the next period shall be increased from the rate determined under sec. 160 of this chapter by an amount sufficient to reimburse all members the amounts assessed.

(b) No assessment may be reimbursed to members without prior approval of the director and no interest accrues in favor of members on amounts assessed.

(c) If, after establishing required reserves, there is an excess amount in reserve, the excess premium shall be refunded to the insured health care providers.

Sec. 21.88.190. REPORTS. At least annually the association shall report to the director concerning its affairs. The report shall be in the form prescribed by the director.

ARTICLE 4. LOAN FUND.

Sec. 21.88.210. FUND ESTABLISHED. (a) There is in the Department of Commerce and Economic Development a medical malpractice liability revolving loan fund to be administered by the director of insurance.

(b) Loans shall be made from the fund to the Joint Underwriting Assoication upon certification by the director that a loan is necessary for the corporation to spread costs out over time because of fluctuations in loss experience. If a loan is made to the corporation from the fund, the Joint Underwriting Association shall issue a note to the fund pledging the premiums collected in the future as security for the loan.

(c) Loans from the fund shall be repaid by the Joint Underwriting Association within four years at an annual interest rate of seven per cent.

(d) The director may sell at par value to the Department of Revenue the notes, security instruments and pledge agreements held by the Department of Commerce and Economic Development as security for loans made under this section. The Department of Revenue shall purchase all the notes offered until the current principal amount of the notes purchased and held by the Department of Revenue equals $5,000,000.

ARTICLE 5. GENERAL PROVISIONS.

Sec. 21.88.900. DEFINITIONS. As used in this chapter,

(1) "association" means the Health Care Providers Joint Underwriting Association;

(2) "corporation" means the Health Care Providers Indemnity Corporation;

(3) "health care provider" means a physician licensed under AS 08.64 and a hospital licensed under AS 18.20.

* Sec. 4. AS 21.18.090 is amended by adding a new paragraph to read:

(5) reserves for the Joint Underwriting Association are to include claims reported and unpaid; reserves for claims incurred but not reported, but those which may reasonably be expected to be reported beyond three years after the date of occurrence may be included on a different basis due to the additional financial flexibility of the association.

* Sec. 3~~0~~5. AS 08.02 is amended by adding a new section to read:

Sec. 08.02.020. LIMITATION OF LIABILITY FOR MEMBERS OF LICENSING BOARDS. No person is liable for damages or other relief in an action by reason of his performance of a duty, function, or activity as a member of a licensing board or by reason of a recommendation or action of the board when the person acts in the reasonable belief that his action or recommendation is warranted by facts known to him or to the board after reasonable efforts to ascertain the facts upon which the action or recommendation is made.

* Sec. 3~~7~~6. AS 08.64.365 and AS 08.68.040 are repealed.

* Sec. 3~~8~~7. This Act takes effect 30 days after enactment.

Our intent was to tie this in with FDA guide on drug Equivalences.

1. Voluntary Binding Arbitration
2. Mandatory Arbitration - Right Trial De Novo
3. Straight to Court if both agree and don't want arbitration

Residential Community Action Group

labor agreement

Press

IN THE HOUSE BY THE JUDICIARY COMMITTEE

HOUSE BILL NO. 842

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to pay differentials between state ferry employees residing inside and outside the state."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 23.40.040 is amended to read:

Sec. 23.40.040. COLLECTIVE BARGAINING AGREEMENT. The commissioner of public works or his authorized representative, in accordance with secs. 10 - 30 of this chapter, may negotiate and enter into collective bargaining agreements concerning wages, hours, working conditions, and other employment benefits with the employees of the division of marine transportation engaged in operating the state ferry system as masters or members of the crews of vessels or their bargaining agent. No collective bargaining agreement is final without the concurrence of the commissioner of public works. The commissioner of public works may make provision in the collective bargaining agreement for the settlement of labor disputes by arbitration, and for area differentials in pay as between employees residing inside and outside the state, not to exceed six pay steps.

Call Compton
Call A. G.

In addition to action under sec. 170 of this chapter, upon a finding that by reason of demonstrated competence, experience, or education the authority to practice chiropractic should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 3. AS 08.32 is amended by adding new sections to read:

Sec. 08.32.015. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if the person's employer maintains insurance for him in the required amounts.

(b) The commissioner of commerce and economic development may require all persons licensed under this chapter to obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for dental hygienists is impairing the delivery of dental hygienists' services to the public.

Sec. 08.32.165. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 160 of this chapter, upon a finding that by reason of demonstrated competence, experience, or education the authority to practice dental hygiene should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

Dentists

* Sec. 4. AS 08.36 is amended by adding new sections to read:

Sec. 08.36.115. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance against liability to patients for dental malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The commissioner of commerce and economic development may require all persons licensed under this chapter to obtain the insurance required under (a) of this section fro. the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for dentists is impairing the delivery of dentist services to the public.

Sec. 08.36.325. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 320 of this chapter, upon a finding that by reason of demonstrated competence, experience, or education the authority to practice dentistry should be limited or conditioned or the practitioner disciplined, the board may censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

Physicians

* Sec. 5. AS 08.64 is amended by adding new sections to read:

Sec. 08.64.215. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance issued by the Health Care Providers Indemnity Corporation against liability to patients for medical malpractice in limits of not less than

$200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts from MIC.

(b) The commissioner of commerce and economic development or his designee may waive the requirement in (a) of this section for a person if that person furnishes satisfactory evidence of his having other insurance providing coverage in amounts not less than those specified in (a) of this section. No waiver granted under this subsection may extend beyond the normal expiration date of the person's insurance policy or January 1, 1977, whichever occurs first.

Sec. 08.64.312. CONTINUING EDUCATION REQUIREMENTS. (a) The board shall promote a high degree of competence in the practice of medicine by requiring every physician licensed in the state to fulfill continuing education requirements.

(b) Before a license may be renewed the licensee shall submit evidence satisfactory to the board of his successful completion of 15 hours of continuing education annually in medicine as prescribed by regulations of the board. Courses approved by the board shall include, but are not limited to, review courses and instruction on new techniques and developments in medicine.

(c) The board may exempt a physician from the requirements of (b) of this section upon an application by him giving evidence satisfactory to the board that he is unable to comply with the requirements because of extenuating circumstances. However, no person may be exempted from more than 15 hours of continuing education in a five year period.

Sec. 08.64.325. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 330 of this chapter, upon a finding that by reason of demonstrated competence, experience, or education the [illegible] to practice under this chapter should be limited or condi-

tioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 6. AS 08.68 is amended by adding new sections to read:

Sec. 08.68.165. INSURANCE REQUIRED. (a) To be eligible for an active license as a nurse under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The commissioner of commerce and economic development may require all persons licensed under this chapter to obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for nurses is impairing the delivery of nurse services to the public.

Sec. 08.68.275. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 270 of this chapter, upon a finding that by reason of demonstrated competence, experience, or education the authority to practice nursing should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

* Sec. 7. AS 08.71 is amended by adding new sections to read:

Sec. 08.71.165. INSURANCE REQUIRED. (a) To be eligible for an

active license under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The commissioner of commerce and economic development may require that all persons licensed under this chapter obtain the insurance required under (a) of this section if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for dispensing opticians is impairing delivery of the services of dispensing opticians to the public.

Sec. 08.71.175. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under sec. 170 of this chapter, upon a finding that by reason of demonstrated competence, experience, or education the authority to practice as a dispensing optician under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by procedure or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

optometrists

* Sec. 8. AS 08.72 is amended by adding new sections to read:

Sec. 08.72.115. INSURANCE REQUIRED. (a) To be eligible for an active license under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The commissioner of commerce and economic development may require all persons licensed under this chapter to obtain insurance

required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for optometrists is impairing delivery of optometrist services to the public.

Sec. 08.72.255. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) In addition to action under secs. 240 and 250 of this chapter, upon a finding that by reason of demonstrated competence, experience, or education the authority to practice optometry under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

pharmacists

* Sec. 9. AS 80.80 is amended by adding new sections to read:

Sec. 08.80.115. INSURANCE REQUIRED. (a) To be eligible for active registration as a pharmacist, a person must maintain insurance against liability to patients for malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The commissioner of commerce and economic development may require that all persons licensed under this chapter obtain the insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for pharmacists is impairing delivery of pharmacist services to the public.

Sec. 08.80.265. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) [illegible] of this chapter, upon a finding that by reason of demonstrated competence, experience, or education the

authority to practice pharmacy under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any action taken by the board under this section.

Sec. 10. AS 08.84 is amended by adding new sections to read:

Sec. 08.84.035. INSURANCE REQUIRED. (a) To be eligible for active registration as a physical therapist under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The commissioner of commerce and economic development may require that all persons licensed under this chapter obtain the insurance required in (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for physicial therapists is impairing delivery of physical therapist services to the public.

Sec. 08.84.185. LIMITS OR CONDITIONS ON LICENSE. (a) In addition to action under sec. 180 of this chapter, upon a finding that by reason of demonstrated competence, experience, or education the authority to practice physical therapy should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by specialty, procedure, or facility, or require continuing education or retraining.

(b) The Administrative Procedure Act (AS 44.62) applies to any

* Sec. 11. AS 08.36.120 is amended to read:

Sec. 08.86.120. ENTITLEMENT TO LICENSURE. A person who passes the examination given by the board and possesses the insurance required by sec. 125 of this chapter is entitled to be licensed as a psychologist

* Sec. 12. AS 08.86.160 is amended to read:

Sec. 08.86.160. ASSOCIATES: ENTITLEMLNT TO LICENSURE. A person who passes the examination given by the board and who possesses insurance in accordance with sec. 125 of this chapter is entitled to be licensed as a psychological associate.

* Sec. 13. AS 08.86 is amended by adding new sections to read:

Sec. 08.86.125. INSURANCE REQUIRED. (a) To be eligible for active licensure as a psychologist under this chapter, a person must maintain insurance against liability to patients for malpractice in limits of not less than $200,000 per occurrence and $600,000 aggregate liability per year. This requirement is satisfied if a person's employer maintains insurance for him in the required amounts.

(b) The commissioner of commerce and economic development may require all persons licensed under this chapter to obtain insurance required under (a) of this section from the Health Care Providers Indemnity Corporation if, after public hearing, he finds that unavailability of malpractice insurance on the voluntary market for psychologists is impairing the delivery of psychologist services to the public.

Sec. 08.86.220. LIMITS OR CONDITIONS ON LICENSE; DISCIPLINE. (a) Upon a finding that by reason of demonstrated competence, experience, or education the authority to practice psychology or as a psychological associate under this chapter should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice by time, specialty, procedure, or facility,

[illegible] continuing education or retraining.

(c) The Administrative Procedure Act (AS 44.62) applies to any

action taken by the board under this section.

Sec. 14. AS 09.55.530 is repealed and re-enacted to read:

ARTICLE 6. MALPRACTICE ACTIONS.

Sec. 09.55.530. DECLARATION OF PURPOSE. The legislature finds that the health of the people is threatened by curtailment of health care services due to the difficulty in obtaining adequate malpractice insurance at a reasonable cost. It is the purpose of secs. 530 - 560 of this chapter to protect the health and safety of the people of this state by establishing procedural aids for handling malpractice claims which will help ensure the ready availability of adequate insurance at a reasonable cost and which will be fair to all parties concerned.

Sec. 15. AS 09.55 is amended by adding a new section to read:

Sec. 09.55.536. EXPERT ADVISORY PANEL. (a) In any action for damages due to personal injury or death based upon the provision of professional services by a health care provider, the court shall establish a three-person expert advisory panel in accordance with this section. When the action is filed the court shall, by order, determine the professions or specialties to be represented on the expert advisory panel and shall advise each party of the professions or specialties to be represented, giving the parties the opportunity to object or make suggestions. The court may in its discretion conduct other preliminary proceedings relative to the composition of the panel as it considers appropriate.

(b) The expert advisory panel may compel the attendance of witnesses, [physically or orally examine the parties,] consult with the specialists or learned works they consider appropriate, and compel the production of and examine all relevant hospital, medical, or other records, relating to the health care treatment. The panel may meet in [CONT'D], shall maintain a record of any testimony or oral statements

of witnesses, and shall keep copies of all written statements and opinions it receives. Not less than 30 days after selection of the panel, it shall make a written report to the parties and to the court, substantially answering the following questions in addition to any other question which the court puts to the panel:

(1) Was the claimant adversely affected by any act or omission in the rendering of the medical services?

(2) What was the adverse effect?

(3) How did the medical services alter the natural course of the preexisting disorder for which the services were originally rendered?

(4) How did the medical condition existing after performance of the medical services differ from the medical condition which might otherwise have been expected?

(c) In any case in which the answer to one or more of the questions under (b) of this section depends upon the resolution of factual questions which are not the proper subject of expert opinion, the report shall so state and may answer questions based upon hypothetical facts that are fully and completely set out in the opinion. The report shall include copies of all written statements, opinions, or records relied upon by the panel and either a transcription or other record of any oral statements or opinions; shall specify any medical or scientific authority relied upon by the panel; and shall include the results of any physical or mental examination performed on the plaintiff. Each member shall sign the report and his signature constitutes his adoption of all statements and opinions contained in it; however, a member may, instead of signing the report, submit a concurring or dissenting report which complies with the requirements of this subsection, and a member may not attest to any portion of the report as to which he is not qualified to

give expert testimony.

(d) No discovery may be undertaken in a case until the report of the expert advisory panel is received. However, the court may relax this prohibition upon a showing of good cause by any party. If the panel has not completed its report within the 30-day period prescribed in (b) of this section, the court may, upon application, grant it an additional 30 days.

(e) The report of the panel and any dissenting or concurring opinion are admissible in evidence to the same extent as though its contents were orally testified to by the person or persons preparing it. The court shall delete any portion that would not be admissible because of lack of foundation for opinion testimony, or otherwise. Either party may submit expert testimony to support or refute the report. The jury shall be instructed in general terms that the report shall be considered and evaluated in the same manner as any other expert testimony. Any member of the panel may be called by any party and may be cross-examined as to the contents of the report or of his dissenting or concurring opinion.

(f) Members of a panel are entitled to travel expenses and per diem in accordance with state law pertaining to members of boards and commissions for all time spent in preparing its report and matters incidental to it. If a panel member is called upon as a witness at trial or upon deposition, he is entitled to payment of an expert witness fee. All expenses incurred by panel shall be paid by the state. However, in any case in which the court determines that a party has made a patently frivolous claim or a patently frivolous denial of liability, it shall order that all costs of the expert advisory panel be borne by the party making that claim or denial.

(g) Parties to the case and their counsel may not initiate communicate ~~out~~ one with

of the award which is paid on periodic basis shall be increased by an annual interest rate of seven per cent from the date the award is made. In this subsection, future damages include damages for future medical treatment, care or custody, loss of future earnings, or loss of bodily function of the claimant.

(c) Except when the collateral source is a federal program which by law must seek subrogation, an award to which a claimant is entitled may only cover damages which exceed any amounts received by the claimant as compensation for his injuries from collateral sources, whether private, group, or governmental, and whether contributory or noncontributory, except life insurance. Evidence of damages compensated by a collateral source, other than a federal program which must seek subrogation, is admissible after the fact finder has rendered its award. Notwithstanding other provisions of state law and except as provided in this subsection, a collateral source does not have a right of subrogation.

* Sec. 18. AS 09.55.550 is amended to read:

Sec. 09.55.550. JURY INSTRUCTIONS. In health care [MEDICAL] malpractice actions the jury shall be instructed that the plaintiff has the burden of proving [, BY A PREPONDERANCE OF THE EVIDENCE,] the health care provider's negligence or wilful misconduct in accordance with sec. 540 of this chapter [OF THE PHYSICIAN OR DENTIST]. The jury shall be further instructed that injury alone does not raise a presumption of the health care provider's [PHYSICIAN'S OR DENTIST'S] negligence or misconduct.

* Sec. 19. AS 09.55 is amended by adding new sections to read:

Sec. 09.55.556. INFORMED CONSENT. (a) A health care provider is liable for failure to obtain the informed consent of a patient if the claimant establishes by a preponderance of the evidence that the provider

~~of court with~~ members of the panel on the subject matter of its inquiry and report or cause or solicit others to do so, except through ordinary discovery proceedings.

Sec. 16. AS 09.55.540 is amended to read:

Sec. 09.55.540. BURDEN OF PROOF. (a) In a malpractice action based on the negligence or wilful misconduct of a health care provider [PHYSICIAN LICENSED UNDER AS 08.64, OR A DENTIST LICENSED UNDER AS 08.-36], the plaintiff has [SHALL HAVE] the burden of proving

(1) the degree of knowledge or skill possessed or the degree of care ordinarily exercised under the circumstances, at the time of the act complained of, by health care providers in the field or specialty in which the defendant is practicing [BY PHYSICIANS OR DENTISTS PRACTICING THE SAME SPECIALTY IN SIMILAR COMMUNITIES TO THAT IN WHICH THE DEFENDANT PRACTICES];

(2) that the defendant either lacked this degree of knowledge or skill or failed to exercise this degree of care; and

(3) that as a proximate result of this lack of knowledge or skill or the failure to exercise this degree of care the plaintiff suffered injuries that would not otherwise have been incurred.

(b) In malpractice actions there is [SHALL BE] no presumption of negligence on the part of the defendant.

* Sec. 17. AS 09.55 is amended by adding a new section to read:

Sec. 09.55.546. AWARDS, COLLATERAL SOURCES. (a) In a malpractice action damages shall be awarded according to the principles of the common law. The fact finder, in rendering its award for damages, shall specify the amount awarded for each category of loss. Awards for loss of future earnings shall be ~~[made]~~ paid out computed on a monthly basis. The court may

periodic payments rather than by a lump sum payment; however, any part

has failed to inform the patient of common risks and reasonable alternatives to the proposed treatment or procedure, and that, but for that failure, the claimant would not have consented to the proposed treatment or procedure.

(b) It is a defense to any action for health care malpractice based upon an alleged failure to obtain such an informed consent that

(1) the risk not disclosed is too commonly known or is too remote to require disclosure;

(2) the patient stated to the health care provider that he would undergo the treatment or procedure regardless of the risk involved, or that he did not want to be informed of the matters to which he would be entitled to be informed;

(3) under the circumstances consent by or on behalf of the patient was not possible; or

(4) the health care provider, after considering all of the attendant facts and circumstances [and consulting with two other health care providers] used reasonable discretion as to the manner and extent to which the alternatives or risks were disclosed to the patient because he reasonably believed that the manner and extent of such a disclosure would reasonably be expected to adversely and substantially affect the patient's condition.

Sec. 09.55.560. DEFINITIONS. In secs. 530 - 560 of this chapter

(1) "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.-72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; and

a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital;

(2) "panel" means an expert advisory panel established under sec. 536 of this chapter.

* Sec. 20. AS 09.65.090 is repealed and re-enacted to read:

Sec. 09.65.090. CIVIL LIABILITY FOR EMERGENCY AID. (a) A person, at a hospital or at any other location, who renders emergency care or emergency counseling to an injured, ill, or emotionally distraught person who reasonably appears to the person rendering the aid to be in immediate need of emergency aid in order to avoid serious harm or death is not liable for civil damages as a result of an act or omission in rendering emergency aid.

(b) This section does not preclude liability for civil damages as a result of gross negligence or reckless or intentional misconduct.

* Sec. 21. AS 18.20 is amended by adding new sections to read:

Sec. 18.20.045. INSURANCE REQUIRED. Every hospital, as a condition of licensure, shall submit to the department and maintain evidence of insurance against liability to inpatients and outpatients for malpractice issued by the Health Care Providers Indemnity Corporation, in amounts of not less than $200,000 per occurrence, and an aggregate liability per year of not less than $1,000,000 for every 50 beds or fraction of that number for which the hospital is licensed.

Sec. 18.20.075. RISK MANAGEMENT. (a) To be eligible for a license each hospital shall have in operation an internal risk management program which shall

(1) investigate the frequency and causes of adverse incidents in hospitals which cause injury to patients;

(2) develop and implement measures to minimize the risk of injury to patients from adverse incidents; in developing these measures

each hospital shall take into account recommendations of private underwriters, industry standards, experience of other hospitals, and recommendations of licensing boards of other health care providers; and

(3) analyze patient grievances which relate to patient care.

(b) The department shall adopt by regulation and submit to the legislative administrative regulation review committee prior to implementation standards for risk management programs in hospitals in the state which may vary according to the size of the hospital, the type of care offered by the hospital, and other factors found relevant by the department.

* Sec. 22. AS 18 is amended by adding a new chapter to read:

CHAPTER 23. HEALTH CARE SERVICES INFORMATION.

Sec. 18.23.010. LIMITATION ON LIABILITY FOR PERSONS PROVIDING INFORMATION TO REVIEW ORGANIZATION. (a) No person providing information to a review organization is subject to action for damages or other relief by reason of having furnished that information, unless the information is false and the person providing the information knew or had reason to know the information was false.

(b) No privilege of confidentiality arising from a physician-patient relationship may be invoked to withhold pertinent information from review by a review organization.

Sec. 18.23.020. LIMITATION ON LIABILITY FOR MEMBERS OF REVIEW ORGANIZATIONS. No person who is a member or employee of, or who acts in an advisory capacity to, or who furnishes counsel or services to, a review organization is liable for damages or other relief in an action brought by a person whose activities have been or are being scrutinized or reviewed by a review organization, by reason of his performance of a duty, function or activity of the review organization, unless the performance of the duty, function or activity was motivated by malice

toward the affected person. No person is liable for damages or other relief in an action by reason of his performance of a duty, function, or activity as a member of a review organization or by reason of a recommendation or action of the review organization when the person acts in the reasonable belief that his action or recommendation is warranted by facts known to him or to the review organization after reasonable efforts to ascertain the facts upon which the review organization's action or recommendation is made.

Sec. 18.23.030. CONFIDENTIALITY OF RECCRDS OF REVIEW ORGANIZATION. (a) Except as provided in (b) of this section, all data and information acquired by a review organization, in the exercise of its duties and functions, shall be held in confidence, may not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review organization, and is not subject to subpoena or discovery. Except as provided in (b) of this section, no person described in sec. 20 of this chapter may disclose what transpired at a meeting of a review organization except to the extent necessary to carry out one or more of the purposes of a review organization, and the proceedings, ~~and~~ records of a review organization are not subject to discovery or introduction into evidence in a civil action against a health care provider arising out of the matter which is the subject of consideration by the review organization. Information, documents, or records otherwise available from original sources are not immune from discovery or use in a civil action merely because they were presented during proceedings of a review organization, nor may a person who testified before a review organization or who is a member of it be prevented from testifying as to matters within his knowledge, but a witness may not be asked about his testimony before a review organization or opinions formed by him as a result of its hearings, except as provided in (b) of this section.

(b) Testimony, documents, proceedings, records, and other evidence adduced before a review organization that are otherwise inaccessible under this section may be obtained by a health care provider who claims that denial is unreasonable or may be obtained under subpoena or discovery proceedings brought by a plaintiff who claims that information provided to a review organization was false and claims that the person providing the information knew or had reason to know the information was false.

(c) Nothing in this chapter prevents a person whose conduct or competence has been reviewed under this chapter from obtaining, for the purpose of appellate review of the action of the review organization, any testimony, documents, proceedings, records and other evidence adduced before the review organization.

Sec. 18.23.040. PENALTY FOR VIOLATION. Other than as authorized by sec. 30 of this chapter, a disclosure of data and information acquired by a review committee or of what transpired at a review meeting is a misdemeanor and punishable under AS 11.05.010.

Sec. 18.23.050. PROTECTION OF PATIENT. Nothing in this chapter relieves a person of liability which he has incurred or may incur to a person as a result of furnishing health care to the patient.

Sec. 18.23.060. PARTIES BOUND BY REVIEW. When a review organization reviews matters under sec. 70(5)(H) of this chapter no party is bound by a ruling of the organization in a controversy, dispute or question unless he agrees in advance, either specifically or generally, to be bound by the ruling.

Sec. 18.23.070. DEFINITIONS. In this chapter, unless the context otherwise requires,

(1) "administrative staff" means the staff of a hospital or clinic;

(2) "health care" means professional services rendered by a health care provider or an employee of a health care provider, and services furnished by a sanatorium, rest home, nursing home, boarding home or other institution for the hospitalization or care of human beings;

(3) "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.-72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; and a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital;

(4) "professional service" means service rendered by a health care provider of the type he is licensed to render;

(5) "review organization" means a hospital governing body or a committee whose membership is limited to health care providers and administrative staff, except where otherwise provided for by state or federal law, and which is established by a hospital, by a clinic, by one or more state or local associations of health care providers, by an organization of health care providers from a particular area or medical institution, or by a professional standards review organization established under 42 U.S.C., sec. 1320(c)(1) et seq., to gather and review information relating to the care and treatment of patients for the purposes of

(A) evaluating and improving the quality of health care [illegible] area or medical institution;

(B) reducing morbidity or mortality;

(C) obtaining and disseminating statistics and information relative to the treatment and prevention of diseases, illness and injuries;

(D) developing and publishing guidelines showing the norms of health care in the area or medical institution;

(E) developing and publishing guidelines designed to keep the cost of health care within reasonable bounds;

(F) reviewing the quality or cost of health care services provided to enrollees of health maintenance organizations;

(G) acting as a professional standards review organization under 42 U.S.C., sec. 1320(c)(1) et seq.;

(H) reviewing, ruling on, or advising on controversies, disputes or questions between

(i) a health insurance carrier or health maintenance organization and one or more of its insured or enrollees;

(ii) a professional licensing board, acting under its powers of discipline or license revocation or suspension, and a health care provider licensed by it when the matter is referred to a review organization by the professional licensing board;

(iii) a health care provider and his patients concerning diagnosis, treatment or care, or a charge or fee;

(iv) a health care provider and a health insurance carrier or health maintenance organization concerning a charge or fee for health care services provided to an insured or enrollee; or

(v) a health care provider or his patients and the federal or a state or local government, or an agency of the

federal or a state or local government;

(I) acting on the recommendation of a credential review committee or a grievance committee.

* Sec. 23. AS 21 is amended by adding a new chapter to read:

CHAPTER 88. HEALTH CARE PROVIDERS INSURANCE.

ARTICLE 1. PURPOSE.

Sec. 21.88.010. PURPOSE OF CHAPTER. It is the purpose of this chapter to provide a means of assuring all health care providers with continuous, affordable and adequate insurance against liability for medical negligence by concentrating all such insurance in one entity [which can negotiate more successfully for insurance from casualty insurers licensed by this state] and to distribute equitably the cost of the insurance among the health care providers insured.

ARTICLE 2. INDEMNITY CORPORATION.

Sec. 21.88.020. CORPORATION CREATED. There is created the Alaska Health Care Providers Indemnity Corporation which is a public corporation having a legal existence independent of and separate from the state. Obligations issued by the corporation do not constitute a debt liability or obligation of the state or a pledge of full faith and credit of the state.

Sec. 21.88.030. CORPORATION BOARD OF GOVERNORS. (a) The corporation shall exercise its powers through a board of governors which shall be appointed by the director as provided in (b) of this section.

(b) The appointments to the board of governors shall be Alaska residents as follows:

(1) one member of the Alaska State Medical Association appointed from a list of no less than three persons recommended by the governing board of that association;

(2) one member of the Alaska State Hospital Association

appointed from a list of no less than three persons recommended by the governing board of that association;

(3) ~~three~~ two professionals in the insurance field;

(4) ~~three~~ two persons who are not ~~attorneys~~, health care providers, or ~~representatives of~~ affiliate Local the insurance industry.

(5) One physician from clinical group practice in Ak.

(c) The term of office of each governor is three years, except that the director shall designate three initially appointed governors to serve for one year and two initially appointed governors to serve for two years.

(d) Upon the expiration of the term of a governor, the director shall appoint a successor who shall be from the same class described in (b) of this section as the governor whose term has expired.

(e) Upon a governor's early resignation, death or inability to serve, the director shall appoint a successor from the same class defined in (b) of this section as the terminating governor, who shall serve for the unexpired term.

(f) The director or his designee is not a voting member of the board of governors but shall be notified by the board of and have the right to attend and participate in all meetings and proceedings of the board.

(g) Each member of the board of governors shall be allowed compensation for services and reimbursement for reasonable expenses incurred in attending meetings of the board and transacting corporation business, [as set out in the plan of operation.] $100/day + travel

Sec. 21.88.040. CORPORATION PLAN OF OPERATION. (a) Within 30 days after the effective date of this chapter, the board of governors shall prepare and submit to the director for approval a plan of operation which provides for the fair, reasonable and equitable administra-

for which it is created. The plan and any amendments of it become effective upon the director's approval. If the board of governors has failed to submit a plan of operation, or if at any subsequent time the board of governors fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate a plan of operation or amendments which are necessary or advisable to effectuate the provisions of this chapter. Adoption of the plan is not subject to the Administrative Procedure Act (AS 44.62).

(b) The plan of operation shall

(1) establish the procedures by which all the powers and duties of the corporation specified in sec. 50 of this chapter shall be performed;

(2) establish procedures for handling assets and discharging liabilities of the corporation;

(3) establish regular places and times for meetings of the board of governors;

(4) establish procedures for records to be kept of all financial transactions of the corporation, its agents, and the board of governors;

[(5) establish the amount and method of reimbursing and compensating members of the board of governors;]

(6) establish procedures for awarding contracts to carry out the provisions of this chapter;

(7) establish the procedures for issuing contracts of insurance as provided in sec. 50 of this chapter and for the determination of rates;

(8) contain additional provisions necessary or proper for the [illegible] of the corporation.

Sec. 21.88.050. POWERS AND DUTIES OF THE CORPORATION. (a) The

corporation shall

(1) issue to all health care providers who pay the premiums for it a contract on an occurrence basis indemnifying the health care provider and his employees who are health care providers against loss by reason of liability and agreeing to tender on behalf of the health care provider and his employees who are health care providers a defense of the health care provider in a proceeding brought under AS 09.55.530 - 09.55.560; the limit of liability shall be no less than the minimum liability coverage required to be maintained as stated in AS 08.64.215 and AS 18.20.045; the contract shall cover the defense against but need not indemnify a claim for punitive damages; the contract shall cover claims against health care providers

(A) that arise out of professional services performed by the health care provider during the period for which the premium is paid; and, at the option of the health care provider

(B) that arise out of services performed by the health care provider after January 1, 1975 and are filed within three years from the date the services were performed but were not discovered by the health care provider when he chose to take this coverage;

Add: and for an additional premium

(2) charge a premium for the protection provided by the contracts issued under (1) of this subsection which shall be determined by the board of governors in accordance with sec. 70 of this chapter and subject to the approval of the director;

(3) comply with or be subject to AS 21.06.090, 21.06.120, 21.06.140, 21.06.160, 21.06.250; AS 21.09.180, 21.09.190, 21.09.200, 21.09.250, 21.09.280; AS 21.12.020(b), (c), (d), and (e); and chs. 18, [illegible] of this title;

Insurances be included with [illegible]

(4) carry out the obligations of the contracts issued under

(1) of this subsection by defending all covered claims made against insured health care providers and by paying all liabilities which are finally adjudicated against the insured health care provider or which may in the opinion of the corporation reasonably be expected to be finally adjudicated against the health care provider to the extent of the contract obligation;

(5) provide coverage to health care providers for liability under AS 09.55.530 - 09.55.560 in excess of the minimum limits required for licensure as a health care provider, but limited to $1,000,000 for individual health care providers and $5,000,000 for hospitals, if there is a finding by the director that this coverage is unavailable at a reasonable cost and that this coverage can be made available at a reasonable cost through the corporation; if this paragraph is implemented, each health care provider obtaining excess coverage up to these amounts ~~shall~~ may obtain it from the corporation, and the corporation ~~shall~~ may procure reinsurance for all the risks incurred by contracts issued under this paragraph from the private market.

(b) The corporation may

(1) employ or retain persons, individual or corporate, to discharge its obligations and shall pay, by way of salary, wage, fee, or commission, reasonable compensation for those services; employees of the corporation are not considered state employees;

(2) provide coverage to health care providers for other hazards including malpractice liability insurance for other licensed health care providers employed by the physician or hospital if there is a finding by the director that this coverage is otherwise unavailable by reason of the operation of the corporation;

(3) borrow funds from the revolving loan fund established under sec. 110 of this chapter when necessary for the corporation to

MC: Power to contract for management services.

maintain adequate reserves; loans from the fund shall be repaid within four years after the loan is made at an annual interest rate of seven percent and through prospective rate increases;

(4) negotiate and become a party to those contracts as are necessary to carry out the purposes of the corporation;

(5) sue or be sued in the name of the corporation;

(6) provide risk management + services

(7) perform all other acts necessary and proper to effectuate the corporation.

Sec. 21.88.060. STATISTICS. The corporation shall collect, maintain and report information concerning claims against health care providers. All such information shall be on forms prescribed by the director and shall be sufficient to enable a proper determination of losses for rate making and to identify causes and sources of loss for loss control. No less often than annually the corporation shall report to the director, which report shall be kept available to the public, the number and amount of claims filed, reserved, paid, settled and adjudicated during the year, the premiums paid to, and the expenses incurred by the corporation during the year. The director may require that supplemental reports include the names of insured health care providers and the claimants; however, no reports which become publicly available may include the names of health care providers or claimants or information that will permit by inference the identity of specific health care providers or claimants. All information shall be made available to the appropriate licensing boards or agencies.

Sec. 21.88.070. RATES. Rates and rating plans used by the corporation for the policies issued shall be determined for each category of health care provider in accordance with all of the following:

(1) rates for physicians ~~shall~~ may be set as a function of the physician's [gross] * medical revenue;

* changed from previous

* perhaps adjusted gross income as reflected in Fed. Tax

(2) rates for hospitals shall be set as a function of the number of permanent beds in the hospital;

(3) a minimum rate may be set for each category of health care provider or discipline or classification within the license category;

(4) rates may not be excessive; rates are excessive if, after a period of time and with respect to an amount of gross premium which are actuarially credible, the premiums exceed losses incurred by the corporation, including losses paid, reserves for claims reported and unpaid, reserves for claims incurred but not reported, and reasonable expenses for the operation of the corporation;

(5) rates may not be inadequate; rates are inadequate if, based on available actuarial data, the premiums to be paid by the health care providers are or may reasonably be expected to be insufficient to pay for losses incurred by the corporation, including claims paid, reserves for claims reported and unpaid, reserves for claims incurred but not reported, and reasonable expenses for the operation of the corporation;

(6) rates shall be adjusted at least as often as annually;

(7) rates for any policy year shall be calculated to include the adjustment for actual experience of the corporation as developed for the preceding four policy years;

(8) in considering losses to be incurred, changes in the law and national, regional and local trends in medical negligence awards may be considered;

(9) income from investment of reserves shall be considered;

(10) disciplines and classifications within the license categories of health care providers shall be considered;

(11) individual risk underwriting factors shall be considered.

(12) see block arm

Sec. 21.88.080. REQUIRED INSURANCE; CANCELLATION. The corporation shall provide insurance to all health care providers otherwise eligible for licensure under AS 08.64 and AS 18.20. The corporation may provide for installment payment of premiums in which event each installment is due by the date specified. The corporation may cancel any of its policies in the event of nonpayment of any premium or installment on a premium or other charge by mailing or delivering to the insured at the address shown on the policy and to the agency of the state issuing the insured's license written notice stating when, not less than 10 days after notice is received by the insured, the cancellation is effective.

ARTICLE 3. LOAN FUND.

Sec. 21.88.110. FUND ESTABLISHED. (a) There is in the Department of Commerce and Economic Development a medical malpractice liability revolving loan fund to be administered by the director of insurance.

(b) Loans from the fund may be made to the corporation when necessary for the fund to maintain adequate reserves.

(c) Loans from the fund shall be repaid by the corporation within four years at an annual interest rate of seven per cent.

ARTICLE 4. GENERAL PROVISIONS.

Sec. 21.88.300. DEFINITIONS. As used in this chapter,

(1) "corporation" means the Health Care Providers Indemnity Corporation;

(2) "director" means the director of the division of insurance for the State of Alaska;

(3) "fund" means the medical malpractice liability revolving loan fund;

(4) "health care provider" means a physician licensed under AS 08.64 or a hospital as defined in AS 18.20.136, including a hospital or health care facility owned or operated by the state or one or more of

its political subdivisons;

(5) "occurrence basis insurance" is insurance against claims arising during the period of the policy coverage.

* Sec. 24. AS 08.64.365 is repealed.

* Sec. 25. This Act takes effect 30 days after enactment.

HB 574
Med - Malp.
House Judiciary

The Legislature of the State of Alaska
FISCAL NOTE
Second Session - Ninth Legislature

I. REQUEST

Bill Identification: An Act relating to liability for the provision of health care services; changing the Alaska Supreme
Title: Courts Rules of Civil Procedure; and providing for an effective da
Requested by: Fran Ulmer Date:
Return Date Requested: 1-12-76
Agency: Commerce Program: Licensing Professions

II. FISCAL DETAIL

Budget Request Unit(s) Affected: Regulating and Licensing Professions

A. EXPENDITURES: (Thousands of dollars)

	OBJECT	FY 76	FY 77	FY 78	FY 79	FY 80	FY 81
100	PERSONAL SERVICES	0	62.8	69.1	76.0	83.6	91.9
200	TRAVEL	0	5.1	5.6	6.2	6.8	7.5
300	CONTRACTUAL	0	12.9	14.2	15.6	17.2	18.9
400	COMMODITIES	0	1.0	1.1	1.2	1.3	1.4
500	EQUIPMENT	0	14.3	.0	.0	.0	.0
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.						
	TOTAL	0	96.1	90.0	99.0	108.9	119.7

B. FUNDING: (Thousands of dollars)

GENERAL FUND	.0	96.1	90.0	99.0	108.9	119.7
FEDERAL FUNDS						
OTHER						

C. POSITIONS:

PERMANENT/TEMPORARY	0/0	3/	3/	3/	3/	3/
MAN MONTHS (P./T.)	/	36/	36/	36/	36/	36/

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

AS 08.01.070 (4) empowers the nine Boards subject to this bill "to request, through the Department of Commerce and Economic Development, investigation of violations of their laws and regulations." The above titled bill will make specific the Department's authority and responsibility to conduct such investigations. Additionally, the bill will widen the boards' discipline powers to include limiting or restricting licensee practice. The obvious intent is to reduce the incidence of malpractice actions by empowering the boards to take preventive action.

continued

IV. ATTACHMENTS

Budget forms 12 thru 17

V. DATE: 1-13-76 PREPARED BY: Sharon Andrew, Director

REVIEWED BY:

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

12 New Position Summary

Fiscal Note Attached - An Act relating to liability for the provision of health care services; changing the Alaska Supreme Court Rules of Civil Procedure; and providing for an effective da

CLASSIFICATION TITLE (1)	PRIORITY (2)	PCN (3)	PAY RGE. (4)	MTHLY. SALARY (5)	REVISED PROGRAM NO. (6)	TOTAL POSITION COST (7)	BUDGET YEAR (BY) NO. POS. (8)	NO. MO. (9)	ANNUAL AMOUNT AGENCY MAINTENANCE (10)	ANNUAL AMOUNT AGENCY CHANGE (11)	ANNUAL AMOUNT GOVERNOR (12)
1 Public Protection											
2 General Gov't Unit											
3											
4 Chief Investigator-HCS		new	18G	1852		40,421	1	12		22,224	
5 Benefits @ 21%										4,667	
6											
7 Sp. Investigator-HCS		new	15G	1483		34,573	1	12		17,796	
8 Benefits @ 21%										3,737	
9											
10 Clerk Typist III		new	8G	988		21,266	1	12		11,856	
11 Benefits @ 21%										2,490	
12											
13											
14											
15											
16											
17											
18											
19											
20											
21											
22											
23 SALARIES										51,876	
24 OVERTIME											
BENEFITS										10,894	
26 SUB-TOTAL										62,770	
27 VACANCY									%	5.14 %	%
TOTAL ANNUAL AMOUNT										62,770	
PERMANENT FULL TIME: POSITIONS & (months)									( )	3 (36)	( )
PERMANENT PART TIME/SEASONAL: POSITIONS and (months)									( )	( )	( )
TEMPORARY, FULL TIME EQUIVALENT: POSITIONS & (months)									( )	( )	( )
TOTAL MONTHS										36	

BRU Regulating and Licensing of Professions BRU CODE 08-53-5-07-00-00 REVISED

12 PERSONAL SERVICES NEW POSITION SUMMARY

13 Request for New Positions

POSITION TITLE	RANGE	LOCATION	GOVERNOR
Chief Investigator - HCDS	18G	Anchorage	APPROVED ☐ DISAPPROVED ☐

TYPE OF POSITION (PFT, PPT, SEAS)	NEW	MAINT.	CHANGE	PRIORITY	PAGE/LINE
PFT	RPA		XX		

TYPE OF EXPENDITURE	AMOUNT	FUNDING SOURCE GF	OTHER	RECEIPT CODE	DETAIL OF RELATED EXPENSES
PERSONAL SERVICES	26,891	X			22,224 & 4,667 benefits @ 21%
TRAVEL	2,540				6 trips @ 200 plus 30 p.d. days @ 46.66
CONTRACTUAL	4,400				
COMMODITIES	300				stationary, etc.
EQUIPMENT	6,200				office furnishings, recording equip, vehicle
OTHER					
TOTAL	40,421				BRU COMPONENT

JUSTIFICATION:

Position will establish and direct investigative support section for nine boards in health care delivery service industry. Responsibile for conducting special investigations and directing activities of subordinate staff. Will be under general supervision of licensing violations officer, but remain relatively antonomous in case preparation for administrative action to discipline licensees.

BRU: Regulating and Licensing of Professions BRU CODE 08-53-5-07-00-00 REVISED _____

13 PERSONAL SERVICES REQUEST FOR NEW POSITION

13 Request for New Positions

POSITION TITLE	Special Investigator-Health Care Delivery Service	RANGE	15G	LOCATION	Anchorage	GOVERNOR
TYPE OF POSITION (PFT, PPT, SEAS)	PFT	NEW	X	MAINT.		APPROVED / DISAPPROVED
		RPA#		CHANGE	X	PRIORITY ____ PAGE/LINE ____

TYPE OF EXPENDITURE	AMOUNT	FUNDING SOURCE GF	FUNDING SOURCE OTHER	FUNDING SOURCE RECEIPT CODE	DETAIL OF RELATED EXPENSES
PERSONAL SERVICES	21,533				17,796 plus 3737 benefits @ 21% 6 trip
TRAVEL	2,540				@ 200 plus 30 p.d. days @ 46.66 stationary
CONTRACTUAL	4,100				etc.
COMMODITIES	200				of c. furnishings, vehicle, recording equ
EQUIPMENT	6,200				
OTHER					
TOTAL	34,573				BRU COMPONENT

JUSTIFICATION: Under supervision will conduct investigations in health care delivery service industry to prepare and compile evidence necessary to sustain license discipline actions.

BRU: Regulating & Licensing of Professions BRU CODE 08-53-5-07-00-00 REVISED ____

13 PERSONAL SERVICES REQUEST FOR NEW POSITION

13 Request for New Positions

POSITION TITLE	RANGE	LOCATION	GOVERNOR
Clerk Typist III	8G	Anchorage	APPROVED ☐ DISAPPROVED ☐

TYPE OF POSITION (PFT, PPT, SEAS)	NEW	MAINT.	CHANGE	PRIORITY	PAGE/LINE
PFT	X		X		

TYPE OF EXPENDITURE	AMOUNT	FUNDING SOURCE: GF	OTHER	RECEIPT CODE	DETAIL OF RELATED EXPENSES
PERSONAL SERVICES	14,346	X			11,856 + 2490 benefits @ 21%
TRAVEL	0				ofc space telephone and vehicle
CONTRACTUAL	4,400				100 sq. ft. ofc, phone, IBM type + maint.
COMMODITIES	500				agent stationary etc.
EQUIPMENT	2,020				ofc. furnishings & dictaphone
OTHER					
TOTAL	21,266				BRU COMPONENT

JUSTIFICATION: Position will provide general clerical support for two full time staff investigators in health care delivery service industry.

BRU: Regulating & Licensing of Professions BRU CODE 08-53-5-07-00-00 REVISED

13 PERSONAL SERVICES REQUEST FOR NEW POSITION

14. Travel

CODE	TRAVEL CLASSIFICATION	PRIOR YEAR (PY) ACTUAL	CURRENT YEAR (CY) AUTHORIZED	BUDGET YEAR (BY) AGENCY Maintenance	AGENCY Change	AGENCY Request	GOVERNOR'S BUDGET
200	TOTAL TRAVEL				5.1		
210/220	FIELD/ADMINISTRATIVE TRAVEL						
	IN-STATE TRANSPORTATION				2.4		
	IN-STATE PER DIEM				2.7		
	OUT-OF-STATE TRANSPORTATION						
	OUT-OF-STATE PER DIEM						
230	CONVENTIONS AND MEETINGS						
	IN-STATE TRANSPORTATION						
	IN-STATE PER DIEM						
	OUT-OF-STATE TRANSPORTATION						
	OUT-OF-STATE PER DIEM						
920	INTER-AGENCY TRANSFERS (Non-Add)						

EXPLANATION:

Two investigators in health care delivery services. Case load average = 23 1/2 per man, 75% of which are in local area.

12 trips per year at average of $200.00 = $2400.00
12 trips, average 5 p.d. days @ $44.66 = $2680.00

BRU Regulating and Licensing of Professions BRU CODE 08-53-5-09-00-00 REVISED

15 Contractual Services

CODE	CONTRACTUAL SERVICES CLASSIFICATION	PRIOR YEAR (PY) ACTUAL	CURRENT YEAR (CY) AUTHORIZED	BUDGET YEAR (BY) AGENCY Maintenance	AGENCY Change	AGENCY Request	GOVERNOR'S BUDGET
300	TOTAL CONTRACTUAL				12.9		
310	COMMUNICATION SERVICES				2.7		
320	PRINTING AND ADVERTISING				.2		
330	RENTS AND UTILITIES				4.8		
340	REPAIRS, SERVICES AND ALTERATIONS				.5		
350	TRANSPORTATION OF THINGS				.3		
360A	EQUIPMENT RENTAL-HIGHWAY WORKING CAPITAL FUND				2.4		
360B	EQUIPMENT RENTAL-WORD PROCESSING				.0		
360C	EQUIPMENT RENTAL-OTHER				2.0		
370	INSURANCE AND BONDING				.0		
380	PROFESSIONAL FEES AND SERVICES				.0		
390	OTHER				.0		
930	INTER-AGENCY TRANSFERS (Non-Add)				.0		

EXPLANATION:

310: 3 telephones, monthly phone charge and long distance
320: printing and advertising
330: rents and utilities - 400 sq. ft. @ 1.00 per foot per month
340: maintenance on equipment
350: transportation of recording equipment, records, etc.
360A: 2 vehicles at approximately $100.00 per month per car
360C: IBM memory typewriter @ 165.00 per month

	CLK/TYP III	Chief Inves.	Sp. Invest.
310:	.7	1.0	1.0
320:	.0	.2	.0
330:	1.2	1.8	1.8
340:	.5	.0	.0
350:	.0	.2	.1
360A:	.0	1.2	1.2
360C:	2.0	.0	.0

BRU: Regulating and Licensing of Professions BRU CODE 08-53-5-07-00-00 REVISED

16 Commodities

CODE	COMMODITIES CLASSIFICATION	PRIOR YEAR (PY) ACTUAL	CURRENT YEAR (CY) AUTHORIZED	BUDGET YEAR (BY) AGENCY Maintenance	AGENCY Change	AGENCY Request	GOVERNOR'S BUDGET
400	TOTAL COMMODITIES				1.0		
410	CLOTHING						
430	FOOD FOR HUMAN CONSUMPTION						
440	FUEL (OTHER THAN FOR MOTOR VEHICLES)						
450	MAINTENANCE & CONSTRUCTION MATERIALS						
460	MOTOR VEHICLE,PARTS,SUPPLIES & ACCESSORIES						
470	PROFESSIONAL & SCIENTIFIC SUPPLIES						
480	STATIONERY AND OFFICE SUPPLIES				1.0		
490	OTHER SUPPLIES,MATERIALS AND PARTS						
940	INTER-AGENCY TRANSFERS (Non-Add)						

EXPLANATION:

office supplies for three staff positions

BRU Regulating and Licensing of Professions BRU CODE 08-53-5-07-00-00 REVISED

17 Equipment

CODE	EQUIPMENT CLASSIFICATION	PRIOR YEAR (PY) ACTUAL	CURRENT YEAR (CY) AUTHORIZED	BUDGET YEAR (BY) AGENCY Maintenance	AGENCY Change	AGENCY Request	GOVERNOR'S BUDGET
500	TOTAL EQUIPMENT				14.3		
510	VEHICLES, BOATS, AIRPLANES				9.4		
520	OFFICE FURNITURE AND EQUIPMENT				4.0		
530	EQUIPMENT PECULIAR TO THE PROGRAM				.9		
560	SHOP AND MAINTENANCE EQUIPMENT						
590	OTHER EQUIPMENT						
950	INTER-AGENCY TRANSFERS (Non-Add)						

EXPLANATION:

ITEM NO.	DESCRIPTION OF ITEMS REQUESTED	EQUIP. CODE	NO. OF UNITS	UNIT COST	REPLACEMENT	NEW
1	executive desk	520	2	240		480
2	credenza	520	3	240		720
3	bookcase	520	3	90		180
4	[illegible] chair	520	3	125		370
5	executive chair	520	2	180		360
6	secretarial desk	520	1	285		285
7	secretarial chair	520	1	80		80
8	file cabinet	520	2	175		350
9	vehicles	520	2	4700		9400
10	recording equipment	520	2	450		900
11	dictation equipment	520	1	1200		1200

BRU: Regulating and Licensing of Professions BRU CODE 08-53-5-07-00-00 REVISED

Continued -

The concept, of course, is not new, since the purpose of licensing acts is preventive public protection. Historically, however, the emphasis has been on demonstrating a minimum level of competence prior to licensure. Enforcement of standards of practice after licensure has been, for the most part, delegated to private institutions or associations.

Although the obvious intent of this bill is to reduce the incidence of malpractice actions, the real purpose is to help assure an adequate supply of health care delivery personnel, an occupational group which is threatened by soaring malpractice insurance premiums. If this package of bills is enacted, it will not last long if the state is ineffectual in its efforts to reduce malpractice.

To accomplish this, the boards will need a highly sophisticated investigative staff capable of responding quickly to complaints and monitoring the activities of in excess of 8,795 licenses. Unfortunately, there is little data available upon which to base projections of the probable work load. The Anchorage Daily Times, in two separate articles last summer, enumerated some 55 Alaska malpractice cases from 1957 through 1974. This is an average of three known cases per year and represents .034% of Alaska's total licenses in the health care delivery industry.

It should be noted that only one half or 4,398 of these are active licensees, the remainder being in an inactive or lapsed status. They are included because for the majority, reactivating the license is primarily an administrative function which does not require additional demonstration of competency.

Compiling the data necessary to sustain a disciplinary action in this industry in accordance with the Administrative Procedures Act is estimated to require an average of one half man month per case. The above statistics would indicate staffing needs of 1 1/2 man months per year. Assuming the boards responsibilities would require investigative actions on 1% of the active licensees per year raises the number to 47 cases or 23 man months. Two full-time investigators will generate clerical work expected to require the services of one full-time clerk typist III. It cannot be over-emphasized that these projections are based on assumptions which have very little basis since statistical data is almost entirely unavailable.

It has been assumed that this bill will be effective July 1, 1975. Expense projections allow for 10% inflation factor only.

I. REQUEST

Bill No. "An act relating to liability for the provision of health care
Title: services; chagning Alaska Sup. Court's Rules of Civil Procedur
Requested by: Office of the Governor Date: December 31, 1975
Return Date Requested: January 12, 1976
Agency: Commerce & Economic Dev. Program: Insurance

II. FISCAL DETAIL

Budget Request Unit(s) Affected: none

A. EXPENDITURES: (Thousands of dollars)

	OBJECT	FY 76	FY 77	FY 78	FY 79	FY 80	FY 81
100	PERSONAL SERVICES						
200	TRAVEL						
300	CONTRACTUAL						
400	COMMODITIES						
500	EQUIPMENT						
600	LAND & STRUCTURES						
700	GRANTS, CLAIMS, ETC.						
	TOTAL						

B. FUNDING: (Thousands of dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						

C. POSITIONS:

PERMANENT/TEMPORARY	/	/	/	/	/	/
MAN MONTHS (P./T.)	/	/	/	/	/	/

III. ANALYSIS (See Fiscal Note Preparation Instruction , Section III)

No fiscal Note impact

IV. ATTACHMENTS

V. DATE: 1/[illegible]/76 PREPARED BY: [signature]

Approved: [signature]

Adopted

A M E N D M E N T #1 suggested by Revisor of Statutes

TO: CS FOR HOUSE BILL NO. 574

Page 2, line 2: after "demonstrated" insert "lack of"

Page 2, line 25: after "demonstrated" insert "lack of"

Page 3, line 18: after "demonstrated" insert "lack of"

Page 4, line 28: after "demonstrated" insert "lack of"

Page 5, line 21: after "demonstrated" insert "lack of"

Page 6, line 14: after "demonstrated" insert "lack of"

Page 7, line 7: after "demonstrated" insert "lack of"

Page 7, line 29: after "demonstrated" insert "lack of"

Page 8, line 22: after "demonstrated" insert "lack of"

Page 9, line 23: after "demonstrated" insert "lack of"

A M E N D M E N T #2

Adopted

TO: CS for HOUSE BILL NO. 574

Page 4, line 3: after "him" insert "from the ~~corporation~~" Healthcare Providers Indemnity Corp.

A M E N D M E N T #3 Adopted

TO: CS for HOUSE BILL NO. 574

Page 4, lines 15 - 20: delete all material and insert:

(b) Before a license may be renewed the licensee shall submit evidence to the board that ~~the~~ continuing education requirements prescribed by regulations adopted by the board have been met.

A M E N D M E N T #4 Failed

TO: CS for HOUSE BILL NO. 574

Page 4, between lines 10 and 11: insert the following:

(c) This section does not apply to persons licensed under this chapter who are employed ~~full-time~~ by the federal, state, or local government and do not ~~practice~~ provide healthcare practice outside this employment.

A M E N D M E N T #5

TO: CS for HOUSE BILL NO. 574

Page 5, line 10: delete "$200,000" and insert "$100,000"

Page 5, line 10: delete "$600,000" and insert "$300,000"

A M E N D M E N T #6

Adopted

TO: CS for HOUSE BILL NO. 574

Page 13, line 8: after "proving" insert "by a preponderance of evidence"

A M E N D M E N T #7

Adopted

TO: CS for HOUSE BILL NO. 574

Page 14, between lines 26 and 27, insert:

Sec. 09.55.554. ORAL CONTRACTS. No cause of action against a health care provider arises for breach of an oral contract to provide a cure or achieve a specific medical result.

A M E N D M E N T #8

Adopted

TO: CS for HOUSE BILL NO. 574

Page 15, lines 16 and 17: after "circumstances" and before "used" delete all material

A M E N D M E N T #9

Adopted

TO: CS for HOUSE BILL NO. 574

Page 23, lines 21 - 24: delete all material and insert the following:

(g) Members of the board of governors receive $100 a day when the board meets, and travel ~~and per diem~~ expenses allowed by law.

Page 24, lines 20 and 21: delete all material

A M E N D M E N T #10

Adopted

TO: CS for HOUSE BILL NO. 574

Page 25, line 15: after the semi-colon insert "and, at the option of the health care provider," that... "(B)

A M E N D M E N T #11

Adopted

TO: CS for HOUSE BILL NO. 574

Page 27, between lines 6 and 7, insert the following:

(6) negotiate for and enter into contracts for management services for the corporation;

Renumber remaining paragraphs

Wilson

February 18, 1976

Suggested changes to CS HB 574
by Rodman Wilson, M.D.

Page 4, after line 10 insert:

1 OK "(c) Physicians in full-time, exclusive municipal, state, or federal employment are exempted from the requirement in (a) of this section."

#1 Adopted Page 10, line 24: Delete "physically or orally examine the parties" and replace with "interview and physically examine the injured person if alive"

2 #2 Adopted the parties

3 Page 10, line 28: After "records" add "or materials"

4 Page 13, following line 29:

OK If interest is paid on periodic payments then lump sum payments should be discounted for having the money in hand.

5 Page 15, lines 15-21: Change to read:

OK "(4) The health care provider, after considering all of the attendant facts and circumstances and consulting with the family if any, used reasonable discretion as to the matter and extent to which the alternatives or risks were disclosed to the patient because he believed that full disclosure would adversely affect the patient's condition."

6 #3 adopted Page 17, line 1: After "recommendations of" add "~~the~~ its medical staff,"

#4 adopted 7 Page 23, line 4: Delete "attorneys," change l.5 "affiliated with the insurance industry."

~~8~~ ~~Page 25,~~ line 2: At what date is insurance required?

9 Page 25, lines 16-20: Change to read:

See Block #10 "(B) that arise out of services performed by the health care provider after December 31, 1974 for any period in which the health care provider had no malpractice insurance, except that coverage will not be provided for a claim already filed at the time retroactive insurance is purchased."

10 Page 27, line 30: "gross medical revenue" better left out of statute. Can be negotiated with the profession by the director. Also the profession worries about the confidentiality of individual gross income figures.

OK

Ana

A M E N D M E N T

Adopted

TO: CS for HOUSE BILL NO. 574

ARTICLE 3. LOAN FUND.

Sec. 21.88.110. FUND ESTABLISHED. (a) There is in the Department of Commerce and Economic Development a medical malpractice liability revolving loan fund to be administered by the director of insurance.

(b) Loans from the fund ~~may~~ shall be made to the corporation ~~when~~ upon cert. by Director ... necessary for the ~~fund~~ corporation to maintain adequate ~~minimum capital and surplus~~ reserves. If a loan is made to the corporation from the fund, the corporation shall issue a note to the fund pledging the premiums collected in the future as security for the loan.

(c) Loans from the fund shall be repaid by the corporation within four years at an annual interest rate of seven per cent.

(d) The director may sell or transfer at par value to the Department of Revenue the notes held by the Department of Commerce and Economic Development as security for loans made under this section. The Department of Revenue shall purchase all the notes offered until the current principal amount of the notes purchased and held by the Department of Revenue equals $5,000,000.

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INTERPROFESSIONAL CODE

Colorado Medical Society — Colorado Bar Association

Foreword

The cause of good interprofessional relations should be well served by this code jointly developed by committees of the Colorado Medical Society and the Colorado Bar Association. The code is intended to be an instrument for better understanding of the problems existing between attorneys and physicians with reference to medical testimony. For those with years of experience in either profession, portions of the code may seem elementary. An occasional reminder, however, is never unimportant when it relates to fundamentals. More significant is the long-range purpose of the code: to prepare the new practitioner of either law or of medicine for matters in interprofessional relations of which he would be almost entirely unaware until he encountered them as problems in his practice. Forewarned, the practitioner may be able to avoid the problems altogether.

This Interprofessional Code constitutes the further recognition that with the great developments in the science and art of both medicine and law, it is inevitable that the physician and the attorney are drawn into steadily increasing association, as the law calls with increasing frequency upon medicine for its scientific knowledge and for its evaluation of facts so that the rights of individuals and of the government may be appropriately determined before various tribunals.

Each of the professions has the duty to develop an enlightened and tolerant understanding of the other. Each profession is vitally essential to the very preservation of society. The aims of the two professions are essentially parallel in their services to society, and this necessitates a full understanding at all times and full cooperation when that is called for.

It is an obligation which each profession owes to the other in the best interests of the public as well as in the best interests of the separate reputations of the two professions. Each must keep in mind the differences in the capacities and characteristics of the practitioner of both professions, and that while law and medicine may each be termed a science, each is an inexact science; and such inexactness is and always will be accented by the human limitations of its practitioners.

General Principles

Doctors of medicine and attorneys at law, as members of two professions possessing a close personal relationship with those they serve, have established principles of ethics applicable to the traditions and requirements of their respective callings.

The physician has responsibility for the care of the individual, in health as in disease. He must minister to his patient's needs to the best of his ability and in accordance with the high precepts of the Hippocratic oath.

The attorney is an officer of the court, sworn to support the Constitution of the United States and of the state or states in which he is admitted to practice. As is the physician, he also is pledged to maintain the confidence and to preserve inviolate the secrets of his client. He will not reject, from any consideration personal to himself, the cause of the defenseless or oppressed, nor delay any man's cause for lucre or malice.

Interprofessional Relations

Each profession is obligated by its own stature to respect and honor the calling of the other. Neither the fact nor the appearance of incompetence, corruption, dishonesty, or unethical conduct on the part of individual members of either profession can be tolerated. It follows then that each profession must vigorously support within its own ranks, as well as in the ranks of the other, those ethical concepts which each has found necessary in the public good. One who has chosen to be a physician or an attorney and has been found competent to be such by appropriate authorities, is vested with high responsibilities and privileges to enable him to serve the public with honor, with dignity, and with effectiveness.



1. The Attending Physician and His Patient

In situations where a patient's legal rights are at stake, the patient's physician should promptly furnish the patient's attorney with the medical facts and data pertinent to the case. The physician should accept the further responsibility of explaining such facts in such a manner that the attorney understands them and can determine their relationship to his client's cause. There should be complete cooperation between the physician and the attorney, each assuming his proper responsibility.

It is for the physician to determine the actuality or probability of fact pertaining to his patient's condition. It is for the attorney to determine how and under what circumstances such facts are to be appropriately presented.

Because of the large number of occasions when medical facts are intricate and difficult to understand, the physician should always provide the attorney with a written summary of them for his study. The physician should carefully preserve his own original records, although with express consent of his patient permitting their physical inspection by, or making a copy of relevant portions available to, his patient's attorney.

A physician should never advise on the amount of damages a patient should

seek to recover. The proper province of his professional advice is the extent, degree, or percentage of illness, injury, disability, or similar judgments based upon his professional knowledge of the case. He is not expected to understand technical rules of legal liability, of evidence, or of trial techniques. The latter are the exclusive province of the attorney.

2. The Attorney and His Client

It is part of the attorney's oath on his admission to the bar of this state that he will not counsel or maintain any suit or proceeding which shall appear to him to be unjust, or any defense, except such as he believes to be honestly debatable under the law of the land. He will employ, for the purpose of maintaining the causes confided to him, such means only as are consistent with truth and honor and will never seek to mislead the judge or jury by any artifice or false statement of law or fact.

In discharge of that oath, it becomes the attorney's responsibility to marshal the facts and to obtain professional and other opinion which, in his judgment, are necessary for his client's case and in a manner consistent with his oath and the ethics of his profession.

It is important that the physician understand that legal proceedings in this country are conducted under what is known as the "adversary system." Under that system the attorney occupies a dual position. He is not alone an officer of the court but also the single-minded advocate for his client. He does not and cannot properly represent both sides to a dispute.

This system has developed in recognition of the truth demonstrated countless times that justice can usually be satisfactorily accomplished if the two or more contestants can present their points of view to some neutral third person who can weigh the opposing claims. Such claims are usually presented in the form of testimony which is offered in question and answer form. The judge of a court, the jury, or the officer presiding before an administrative tribunal is the referee who weighs the opposing points of view and the conflicts in testimony. In a sense the judge or administrative officer much more nearly approximates the physician in objectivity. The physician well knows, however, that in some situations it is also possible for medical men to vary honestly and sincerely in their physical findings, their treatment, and their evaluation of illness or injury.



3. Conferences

The physician and the attorney should always confer relative to the common problems presented in a particular case. Such conferences should be arranged in advance of a court or other hearing at the mutual convenience of each, in full appreciation that to each profession, time is of the utmost importance. No physician and no attorney should be required to spend unnecessary time in arranging or attending such a conference. The attorney who knows and understands the progress of his client's case, the conflict, if any, of its medical aspects, and the probability of settlement or trial should determine the necessity of a conference. The physician shall feel obligated to point out anything which he believes will be helpful in presenting the patient's case as well as the weaknesses in the opposing medical theories or testimony.

It is unfair to the patient-client, the physician, and the cause of justice to present a medical witness who has not first conferred with the attorney and who, therefore, may lack a full appreciation of the significance to the case of the particular evidence he is being asked to give. It is equally obvious that the attorney is less able to represent the full interest of his client where he has not had the advantage of full conferences with the physician in advance of presenting the case.

4. Reports to Attorneys

Physicians must appreciate that promptness in providing a patient's attorney with such information as may be available is of importance to the patient's legal rights. Many matters can be settled out of court to the mutual satisfaction of the parties involved. Undue delays in providing medical reports, bearing on a patient's legal rights, may prejudice the patient's opportunity, either as to settlement or disposal of the problem, and thus create possible further expense, worry, and even the loss of important testimony. Witnesses may die or facts become obscure as the time elapses.

As a minimum a physician's reports to his patient's attorney should include the following:

a. History as related by patient
b. Examination
c. Diagnosis
d. Treatment
e. Progress and prognosis

5. The Physician and Court Arrangements

It is the physician's obligation to be in court at the time requested. Timing is not only important for the orderly and advantageous presentation of the patient-client's case, but also for the convenience of the Court, other witnesses, the jury, the attorneys and other litigants. Courts and the attorneys must appreciate, however, that the physician has continuing and often unpredictable responsibilities to his patients. It must therefore be anticipated that at times courtroom procedure must give way to humanitarian considerations and the physician be permitted to testify "out of turn" or at another time. Courts and attorneys should undertake in every way to determine when and approximately how long the doctor of medicine will be needed in court. The doctor should be given as much advance notice as is reasonably possible, so that he can arrange his professional affairs accordingly.



When an emergency arises which calls for the services of a physician witness, judges and attorneys should promptly release such witness or postpone his appearance until the emergency has first been cared for.

6. The Attending Physician on the Witness Stand

The attending physician is a witness. As such he should never assume the role of the advocate. His patient is represented by an attorney who serves in that capacity. The counsel should not engage in examination of the physician as a hostile witness but as a provider of facts. The physician should show respect and consideration to the court and to the attorneys. Such also is the obligation of courts and attorneys to the physician.

If a physician believes that an attorney is omitting an important point in the course of presenting the case or that he is underestimating the importance of medical testimony which is being offered by the other side, he should tell the attorney so, preferably in writing.

7. The Attending Physician and His Charges for Services in Connection with Litigation

The medical profession has long accepted its responsibility to serve the health of the people without regard to race, religion, rank, or ability to pay.

But when the financial circumstances of the patient justify, the physician is entitled to reasonable compensation, as are others who provide such an individual with personal services or commodities. "Reasonable compensation" should include consideration of time spent by the physician in conferences, preparation of required or requested reports, travel costs, and court or other appearances. The attorney must do his full part in explaining that fact to his client.

It is proper and not unusual for an attorney to represent on a contingent fee basis a client who is not in a position to pay a per diem fee irrespective of the

outcome of the case and the attorney may acquire a lien upon the proceeds of the action. The medical profession neither has, nor seeks, any similar arrangement. The charges of a physician should not in any way be based upon a percentage of the patient's financial recovery. Any other practice might lead to a charge that the physician witness had an interest for being partial in his testimony.

8. The Attorney and His Direct Payment of Medical Fees

An attorney under his canons of ethics cannot stir up strife or litigation, and neither can he reward those who may persuade others to seek his service. He cannot "maintain" a suit or other proceeding. This standard presents every practicing attorney with difficult questions. Is he permitted, for example, to advance costs of litigation on behalf of his client? He may do so ethically where such advances constitute a charge to the client, and their collectibility is not contingent upon the outcome of the case. Such advances may be made by the attorney only with the understanding that he is to be reimbursed by his client.

It should be remembered that an attorney, in seeking the services of a physician in connection with a medical-legal matter, acts only as an agent for the client-patient, and incurs no legal obligation on his own behalf for the services of the physician. Nevertheless, professional courtesy on the part of the attorney requires that he exert his best efforts to insure that the client pays for such medical services with reasonable promptness. The attorney, at the time of settlement of a claim in behalf of his client, should, if possible, take steps to make certain that any unpaid medical charges due from his client are paid at that time.



9. Cooperation by Attorney to Assure Physician Payment

Misunderstandings between the two professions sometimes arise in those court cases or administrative proceedings in which it appears that the attorney protects his own fee without making any corresponding effort on behalf of the physician whose treatment in advance of the litigation and whose advice and testimony during the course of it are essential.

There are cases in which the attorney does not advance the fee for the physician's testimony, either because the amount is beyond his means or because he has no reasonable expectation of reimbursement by his client and is therefore not ethically warranted in making such advance.

Still another complication is presented when a physician takes care of a patient who asserts that his injury or illness arose out of or during the course of employment. It may ultimately be determined by an administrative body or a court that the injury did not arise out of employment. In such situation there will be no workmen's compensation award and the physician may remain unpaid. The attorney may then bring civil action and make a recovery with or without the testimony of the original treating physician. Or the physician may have prepared opinion evidence which was for some reason not acceptable to the patient or to his attorney and which, despite the time required and the careful preparation by the physician, may not have been used. In still other cases the testimony of the physician may have been ready, but the case may be settled out of court.

In any of the above situations and in others not here enumerated, the physician may have no protection for his earned professional fee, although it may have been included in the financial settlement. The attorney should, as a matter of fairness and interprofessional courtesy, do everything reasonably possible to assure payment of the services rendered by another professional man in a matter in which he is concerned. It has been held "professionally reprehensible" for an attorney to make a settlement of a case without providing for the physician's fee after he had made such an agreement with the examining physician witness with the client's approval.

10. Expert Testimony

The attorney should understand that in a very real sense, and one recognized by law, every physician is relatively "expert" in the field of medical testimony. The thoroughness and high quality of his training entitles him to this status as does his unlimited license. There is another degree of expertness recognized alike by courts and the profession which comes with specialized training and experience in a particular branch of medical science. It is in this latter sense that the term "medical expert" is more commonly understood and used.

An expert medical witness may or may not have treated the patient. He may or may not have examined the patient. The testimony of an expert must in part depend, then, on the facts of his relationship to the particular patient. His testimony, if he has not treated the patient, cannot be expected to be the same as if he had treated the patient "in the nakedness of his distress." Expert testimony will be still more limited if the physician, even though an acknowledged expert, has never examined the patient but has been limited to X-rays, observations, the reports of other physicians, or to hypothetical questions.

The attorney should take into account the difference between these situations and should not expect a medical expert to offer opinion evidence which exceeds the factual relationship of such expert to the patient, or which exceeds the facts contained within hypothetical questions put to him as the basis for his opinion.

11. Subpoenaed Expert

There are situations in which the attorney subpoenas the medical expert, either because a physician has been uncooperative or the attorney has thought

him so, or the physician has said, for example, that he does not wish to testify, or that he has no opinion. This presents complications from the standpoint of the physician. There is no question of the obligation of the physician to answer to a subpoena like any other citizen, except where grave emergency prevents his doing so. An emergency can never be a matter of mere convenience to the physician. It must always involve the genuine professional needs of a patient, and the physician takes the risk of convincing the Court that the emergency was of sufficient gravity to justify his ignoring the order of the Court.

The most obvious complications presented by a subpoena are: first, it is unlikely to take the demands of the physician's practice or his professional convenience into account; second, the physician is frequently not given enough time to prepare to respond to a subpoena; third, the compensation which accompanies a subpoena is nominal and does not reflect the reasonable value of the professional services involved in preparing or offering court testimony, or the time taken away from a physician's practice.

A physician subpoenaed as a medical expert cannot reasonably be held to special study, review of the authorities and medical literature, or to other specialized preparation in such circumstances.

No medical expert can be compelled to form an opinion, although he may be required to state the substance of his observations if he observed the patient. If he does not have a professionally adequate basis for an opinion as to a particular litigant whom he did not observe, he cannot be compelled to offer an opinion before a court or administrative body. If he has an opinion, he is obliged to state it.

If an attorney is insistent that a medical expert offer an opinion under these circumstances, the physician should be careful to state for the record that he has been subpoenaed, that he has not observed the patient, if such is the case, and that he has an insufficient basis upon which to form a professional opinion.

When a physician who has not observed a particular individual is subpoenaed as a medical expert, he will be confronted with the problem of the hypothetical question. If he can answer that question, he must do so. If he cannot answer it without special study or the question does not contain sufficient facts upon which to form an answer, he should so state.



12. Statements by Physicians to Both Sides

Attorneys are under ethical obligations first, not to handle both sides of a case, and second, not to deal with the parties to the other or adverse side except through the latter's attorney. The principle of adverse interests is not always well understood by the physician who is trained to think only in terms of patient interests. The result is that in some situations physicians may offer observations or opinions to both sides in a particular proceeding or lawsuit or may submit to interviews by attorneys for both parties, and that variations in their opinions may result which can be embarrassing and difficult to explain at a later time.

It is self-evident that a physician's integrity and judgment are among his most precious assets, and that neither should ever be "purchased." On the other hand, when a physician has been asked to offer his testimony on behalf of a patient or as an expert on behalf of a particular claimant, he should not needlessly complicate the case by making himself available to representatives of the other side or by offering apparently inconsistent viewpoints to two or more parties or their attorneys.

When a physician who has agreed to offer testimony on a case is approached by attorneys or other representatives for other parties with adverse interest, he should be frank about his prior commitment, notify the attorney for the party for whom he has agreed to testify, and thereafter be guided by the advice of the latter's attorney.

13. Ethical Limits of Medical Testimony

It is hard to set down in words the proper limits of medical testimony. If a physician has treated a patient on whose behalf he is offering testimony, he must offer the facts of his diagnosis, his treatment, and his prognosis honestly and simply. He should not indulge in speculation unless the case unavoidably requires such indulgence, and in such situation he must clearly label his own testimony as speculative or his "best estimate" or "best judgment."

Under no circumstances is a medical witness justified in suppressing medical evidence or in "taking sides" as such. First, such an attitude goes to the very credibility and usefulness of the testimony. Second, it is an unwarranted usurpation of part of the attorney's function.

If the physician is testifying as an expert, he should offer no opinion beyond the facts of the case or which is not otherwise in the court record or which goes beyond his personal knowledge or runs counter to his professional training and judgment. Violation of these fundamentals is not excusable by claiming that an attorney forced him into the making of an improper statement. His professional judgment and his own conscience must mark the limits of his testimony, including his opinions.

14. Efforts by Attorneys to Influence Medical Testimony

It is improper for an attorney to seek to color the professional opinion of the physician. He may properly point out the kind of medical evidence he needs to establish his case and the reasons for it, but this does not excuse him for trying to force or shape the physician's testimony. It must be remembered that any improperly presented medical testimony is almost always a bilateral product and one which is professionally unworthy of both the physician and the attorney.

As is well stated in Canon 15 of Legal Ethics: "The office of attorney does not permit, much less does it demand of him for any client, violation of law or any matter of fraud or chicane. He must obey his own conscience and not that of his client."



Finally, no ethical attorney is justified in abusing, badgering, or browbeating any witness, including a physician, whether it be one he called or a witness for the other side. Such actions are beneath the dignity of the attorney and are equally in violation of the dignity of the physician. Established rules of evidence give ample opportunity for testing the competence or credibility of a medical witness and make unnecessary and unjustifiable a resort to any of the above devices on the part of the cross-examining attorney. The same holds of examination of a physician who is in fact, or who is believed to be unfriendly to a particular viewpoint and is therefore examined as a "hostile witness."

No judge or other presiding official should tolerate such tactics, but where they do not act promptly, the physician should inquire of the person conducting the hearing whether he is required to submit to such treatment. Rarely will an administrator or judge fail to restore the hearing to a proper level after such a request is made.

15. The Problem of Conflicting Medical Evidence

One of the most common criticisms of medical testimony arises from conflicts between the testimony of two or more physicians with reference to the same case. Physicians are themselves critical of this situation under some circumstances. It is an extremely troublesome matter and one which may be partially solved by the observance of several principles, largely within the control of each of the professions.

The first is that an attorney can reduce the area of misunderstanding out of which conflicting testimony frequently comes by thorough preparation of his case, by a careful use of words, and by a carefully worked out purpose in having certain testimony offered. The second is that the physician can and should explain that medicine is as much an art as it is a science; that in many situations alternative treatments are available, any one of which may be appropriate; that judgment values are not exact but at best fall within rather substantial ranges; that certain risks attend a given procedure; that some cases will not have a successful outcome;

that many diagnoses are limited by the subjectivity of the symptoms and are complicated by the mental outlook of patients; and finally, that diagonsis and treatment must both be evaluated as of the time they occurred rather than in the light of a later day.

16. Choice of Language by Medical Witness

A medical witness testifying before an administrative body, such as an industrial commission, may ordinarily use technical language with relative freedom and confidence. The reason for this is that such bodies become relatively expert in the understanding of his medical vocabulary. That is true in varying measure of judges. It is not true, however, of a jury. It is possible for medical testimony to be so worded technically that its meaning is entirely lost upon a jury or is so completely misunderstood that the jury finds differently than it would if it had known the true import of the testimony.

When this situation occurs, it may be the responsibility of either or both the physician and the attorney. To make his professional testimony clear, both for the record and for physicians and attorneys on the other side, a medical witness should first express his findings and opinion in medical terms. He should then translate those terms as accurately as possible into language intelligible to the court, attorneys, and the jury. He should also put into intelligible language the effect of particular injuries. The latter is frequently easier than the technical statement of a diagnosis or of the treatment rendered.

The medical witness should remember that his testimony is not intended to impress or edify, but to explain. If it does not help explain and does not clarify the issues of a particular case, it has failed in the sense that it was not useful to the determination of the case.

17. Proper Use of Professional Associations

When an attorney is of the opinion that another attorney in the case or a medical witness has acted improperly or has offered improper testimony, he should first seek to remedy the matter during the course of the hearing or litigation itself. Failing that, and if he continues to be of the opinion that a genuine wrong has been done he should refer the case objectively, and without indulgence in personalties to the professional organization of which either the attorney or the physician is a member.

In like manner, a physician, if he is satisfied as a matter of conscience and professional judgment that an attorney has exceeded the limits of propriety in his handling of medical witnesses or in his efforts to introduce improper medical testimony, should report his opinion to the bar association to such effect. He also has the clear obligation of reporting to the appropriate medical organizations one of his own profession who has, in his opinion, acted with apparent impropriety in the course of appearing as a witness.

The making of such a report either against a member of one's own profession or against the member of another profession is one of great delicacy and seriousness. Professional reputation is the most precious and at the same time the most fragile asset of any professional man. Subjecting it to question must be done with fairness, candor, and without rancor, and in the excercise of sound judgment and conscience.

By the same token, merely because of the gravity of the step, no member of either profession should abstain from reporting what he believes a substantial misconduct. At least as much harm can be done from such abstention as from making a groundless charge.

18. A GUIDE FOR MEDICAL LEGAL CHARGES

From Colorado Bar Association Interprofessional Committee: Note/Increases in costs and fees have occurred. Attorneys and doctors are encouraged to settle the amount and manner of payment in advance. Efforts are being made to review, revise and update medical-legal charges but the Interprofessional Code was out of print and it was decided to make reprints available without further delay leaving blanks to insert fees later.

1. This schedule is intended as a guide for the charging of reasonable medical-legal fees. Where the circumstances warrant, greater or lesser charges may be justified and charged by a physician in any particular fact situation.
2. TESTIMONY. One-half day or less — $ _____ .to $ _____ .
   Factors to be considered:
   a. Specialization or not;
   b. Disruption of patient scheduling and office procedure;
   c. Time in preparation;
   d. Advance notification;
   e. Time away from office;
   f. Time actually testifying.
3. REPORTS. $ _____ to $ _____ .
   Factors to be considered:
   a. Form report versus short summary report versus detailed narrative lengthy report.
4. PRE-TRIAL CONSULTATION WITH ATTORNEY. $_____ to $ _____ per hour.
   Note: The sub-committee believes that consultations are desirable in that they work to the establishment of a better relationship between the testifying physician and the patient's attorney and that, in general, consultations result in a shorter trial time and a more lucid explanation of the medical problem involved.
5. CANCELLATIONS. For the physician who receives less than twenty-four (24) hours notice of the cancellation of his time for testifying, he may, in his discretion, charge a fee, not to exceed $ _____ to $ _____ which fee should bear a reasonable relationship to actual financial losses, if any.
6. ADVANCE PAYMENTS. Within twenty-four (24) hours prior to the actual time of testimony, the testifying physician is entitled to receive upon his request a reasonable witness fee paid in advance.
7. MEDICAL SERVICES. The amount charged for medical services is entirely discretionary with the examining physician. This charge is always the sole responsibility of the patient, subject to the guidelines set forth in paragraph 8 of the Interprofessional Code.
8. DISCOVERY DEPOSITION OF MEDICAL EXPERT. Where a medical expert is deposed by either party to an action, the party causing the taking of the deposition may be charged by such expert witness a reasonable fee for the time involved, such fee to be based upon the same hourly rate as might be reasonably charged for a pre-trial consultation as suggested in paragraph 4 hereof.
9. RESPONSIBILITY FOR PAYMENT. The attorney who has caused the incurring of any medical-legal charge shall be ethically responsible to assure the payment of such charge, where such charge does not exceed the maximum suggested by this schedule, to the physician who makes any such charge. The attorney is never responsible for the payment of any charge incurred by a patient for medical treatment but ethically should withhold, with his client's permission, such charge or medical expense from any recovery obtained through the attorney's efforts.

Joint Medico-Legal Plan

for Screening Professional Liability Cases

Colorado Medical Society
Colorado Osteopathic Association
Colorado Chiropractic Association
Colorado Dental Association
Colorado Hospital Association
Colorado Bar Association

1. PURPOSES

The fundamental purpose of this Plan is two-fold: on the one hand, to prevent where possible the filing in court of actions against physicians, chiropractors, dentists, hospitals, health care facilities or their agents or employees for alleged breach of professional duty in situations where the facts do not permit at least a reasonable inference of such breach; and, on the other hand, to make possible the fair and equitable disposition of such claims against physicians, chiropractors, dentists, hospitals, health care facilities or their agents or employees as are, or reasonably may be, well-founded.

2. REPUTATION AND LEGITIMATE GRIEVANCES

The participating groups recognize that the mere filing of an action in court, however unjustified medically it may be, causes substantial harm to the reputation and practice of the concerned physician, chiropractor, dentist, hospital, health care facility, or their agents or employees. The participating groups recognize also that persons having legitimate and meritorious grievances against physicians, chiropractors, dentists, hospitals, health care facilities, or their agents or employees have heretofore often encountered the greatest difficulty in substantiating their claims with expert testimony in court.

3. PANEL IMPARTIALITY

All members serving on the Hearing Panel provided for hereunder must realize that they are appointed for their impartiality, integrity, and judicial temperament, and must not allow personal prejudice or bias to influence their findings or determinations.

4. COMPOSITION OF PANELS

To carry out the purposes of this Plan, the Colorado Medical Society, the Colorado Osteopathic Association, the Colorado Chiropractic Association, the Colorado Dental Association, the Colorado Hospital Association and the Colorado Bar Association shall each designate from its association a member thereof to serve as its Representative. Such Representative shall be responsible for the general supervision and administration of this Plan, and each shall appoint from the membership of his respective association members to serve on each Hearing Panel. The six groups, medical, osteopathic, dental, chiropractic, hospital, and legal (hereafter referred to as the participating groups) shall have equal representation at all times on such Hearing Panels. The Chairman of each panel shall be a member of the Bar Association, and shall be designated by the Bar Association Representative. The Hearing Panel shall consist of six members, three attorneys designated by the Colorado Bar Association Representative, and three Representatives of the participating group whose member is the subject of the claim of malpractice for which the Hearing shall be convened, unless more than one participating group is involved, or unless all parties to the hearing agree to a lesser or greater number.

Where more than one participating group is involved, each such group shall have no fewer than two representatives on the Hearing Panel and the total number of bar

Association panelists shall be equal to the total number of other panelists convened for the Hearing. In such cases, Bar Association panelists shall be, by appointment prior to the hearing, specifically designated by the Bar Association representative to deal with the liability and damage questions of a specific participating group, and shall vote only on questions of such specific group, i.e., in the ultimate questions an attorney designated as an "osteopathic panelist" votes only on questions dealing with the liability of the osteopathic physician concerned.

The specific occupation or profession of Colorado Hospital Association panelists may vary from case to case based upon the particular area of hospital responsibility at issue. Thus, among others, administrators, nurses, records personnel, physicians, or therapists may be panelists. The administrative representative of the Colorado Hospital Association shall consult with the administrative representative of the Bar Association in selecting the specialization of panelists for particular cases involving hospitals.

5. SUBMISSION OF CASES

The screening procedures outlined herein shall apply only to claims of alleged breaches of professional duty commonly referred to as "malpractice" and shall not apply to claims arising out of the maintenance and use of premises or vehicles and other similar claims in negligence or contract.

An attorney may submit a case for the consideration of a Hearing Panel by addressing a request in writing to the Colorado Bar Association, signed by both himself and his client. This letter request shall contain the following:

A. A brief statement of the facts of the case as asserted by the Claimant, showing the persons involved, the dates and the circumstances, so far as they are known, of the alleged breach of professional duty.

B. A statement authorizing the Hearing Panel, through its Chairman, to obtain all medical and hospital records and information pertaining to the incident, and, for the purposes of its consideration of the matter only, waiving his client's privilege as to the contents of those records and information. Nothing in that statement shall in any way be construed as waiving such privilege for any other purpose or in any other context, in or out of court.

C. An agreement that the evidence received or offered at the hearing and the deliberations, discussions and conclusions of the Hearing Panel and of the members thereof will be confidential within the Panel and privileged as to any other person, and that no member of the Hearing Panel or any person attending the hearing will be asked in any action or proceeding to testify concerning the evidence received or offered or the deliberations, discussions, conclusions, or proceedings of such Panel.

D. A request that the Hearing Panel consider the merits of the claim and render its report to him.

E. A list of witnesses, both lay and expert, who may be called by the Claimant's attorney to testify before the Hearing Panel. The purpose for this requirement is to allow the parties in good faith to give notice to the panelists so that any prospective panelist may have an opportunity to disqualify himself if a relationship exists between him and a prospective witness which may affect such panelist's fair and impartial deliberation. Counsel for the respective parties may be free to call additional witness as justice requires, subject to approval by the Chairman of the Hearing Panel.

F. A statement that the attorney has read, understands, and subscribes to this Plan for screening claims against physicians, chiropractors, dentists, hospitals and health care facilities and has advised his client thereof, and that the Claimant and his attorney agree to the submission of the facts pursuant to the Plan. Without such agreement, no action shall be taken on the request for review.

G. At the option of the parties, the letter request may also contain a written statement

by the Claimant and his attorney that such provisions of Rule 109, Colorado Rules of Civil Procedure, as the parties may select in writing shall control disposition of the liability issues of the claim or claims. Such agreement shall not be binding unless all parties to the hearing and their attorneys elect in writing so to be bound.

6. CONSENT OF RESPONDENT

Appended to such request shall be the signed statement of the Respondent physician(s), chiropractor(s), or dentist(s) involved, or authorized representative of the respondent hospital, health care facility, or their agents or employees involved, and of the attorney or attorneys representing such physician, chiropractor, dentist, hospital, health care facility, or their agents or employees, containing the following:

A. Acknowledgement of the receipt of a copy of such request.

B. An agreement that the matter be submitted for the consideration of a Hearing Panel in accordance with this Plan. Without such agreement, no action shall be taken on the request for review.

C. A list of witnesses, both lay and expert, who may be called by the Respondent's attorney to testify before the Hearing Panel. The purpose for this requirement is to allow the parties in good faith to give notice to the panelists so that any prospective panelist may have an opportunity to disqualify himself if a relationship exists between him and a prospective witness which may affect such panelist's fair and impartial deliberation. Counsel for the respective parties may be free to call additional witnesses as justice requires, subject to approval by the Chairman of the Hearing Panel.

7. JURISDICTION

Cases which the Hearing Panel may consider may include any case involving any alleged breach of professional duty by any member of the Colorado Medical Society, Colorado Osteopathic Association, Colorado Chiropractic Association, Colorado Dental Association, Colorado Hospital Association, their agents or employees; provided, however, that nothing herein shall prohibit the Panel from also hearing a claim against any other practitioner of medicine, chiropractic, dentistry or hospital if the parties, the Bar Association, Medical Society, Osteopathic Association, Chiropractic Association, Dental Association, or Hospital Association Representatives, and the members of the Hearing Panel unanimously consent thereto.

8. SCHEDULING—QUORUM

Requests for review submitted as above shall be scheduled for hearing as promptly as possible before a panel constituted as above set forth; provided, however, in no instance shall the date assigned be more than 45 days after the receipt by the Bar Association Representative of the request for review. In any hearing a quorum of the Hearing Panel for the purpose of deciding the issues submitted to it shall consist of a majority of those members of the Hearing Panel who have attended all hearings of the issues.

9. AFFIDAVITS OF PANEL MEMBERS

Each member of the Hearing Panel selected shall be advised of the names of the parties, their addresses and occupations in the case of each claimant and respondent. There also shall be tendered to each member of the Hearing Panel an affidavit to be signed by the member of the Hearing Panel and returned to the designated Chairman of the Hearing Panel no later than five days prior to the hearing date. Such affidavit shall contain the following:

A. That the Hearing Panel member is either not acquainted with the claimant or the respondent, or that such acquaintanceship is on such a basis that it will not interfere with an objective and fair evaluation of the issues to be presented.

B. The affiant has no knowledge of the facts of this claim other than those contained in the claimant's submittal letter or that any prior knowledge will not in any way

prejudice his objective determination of the issues to be resolved herein.

C. That the affiant has no preconceived or inalterable opinion or conclusion concerning the subject matter of the Claimant's submission and knows of no impediment to his being a fair and impartial member of the Hearing Panel.

D. That the affiant endorses and supports the Joint Medico-Legal Plan as a method of resolving or attempting to resolve such claims.

E. That the affiant will not hesitate to render a true and just determination of the issues to be presented and will not be governed or influenced by sympathy or prejudice for or against any party in the case, nor will the affiant be influenced by fear of criticism by other members of his profession.

The attorneys for the parties may not orally question the members of the panel as to their qualifications at the commencement of the hearing, except for good cause shown to prevent manifest injustice. Objection to any member of the Hearing Panel must be made by the parties or their attorneys before evidence is presented at the hearing or such objections shall be deemed to be waived.

10. OPENING STATEMENTS

At the time set for hearing of the case, the Claimant's attorney shall be present and shall state his case, including a resume of the facts constituting the alleged breach of professional duty which he is prepared to prove and the legal theories on which he expects to base such proof. The Respondent and his attorney may be present and should also make a statement of his case, including the legal theories on which he expects to base his defense. No statement by the attorneys or the parties shall preclude the Hearing Panel from consideration of other areas pursuant to the provisions of Paragraph 19 of this Plan; however, if the members of the Hearing Panel do consider other areas, such members of the panel shall inform the parties and their attorneys that such areas are being considered, and an opportunity shall be provided to the parties and their attorneys to present additional testimony if the parties or their attorneys so desire.

11. WITNESSES–ISSUES

Each party may present such testimony and other evidence as may be proper under the provisions hereof relating to rules of evidence to be followed, and any witness called shall be subject to cross-examination by the opposing party and to interrogation by members of the Hearing Panel. The monetary damages, if any, shall not be the subject of inquiry or discussion. The hearing will be conducted informally, and no official record shall be kept. Rules of evidence and procedure applicable to informal administrative proceedings shall be followed. Hospital records and summaries may be reviewed and considered by the Hearing Panel. Written statements of treating physicians may also be received by the Hearing Panel; however, the Panel shall not consider any opinions as to ultimate issues of liability which may be contained in such reports. Relevant medical texts, journals, studies, or other pertinent material may be reviewed and considered by the Panel if the Panel deems such material to be appropriate.

12. RULES OF EVIDENCE–FAILURE OF PROOF

It is the purpose and intent of this Plan that the Panel informally consider all matters relevant to the issues presented, and to this extent formal rules of evidence shall not be followed. The Chairman of the Hearing Panel shall rule on all objections and procedural matters, subject to being overruled by a majority vote of the Panel members. If the parties shall fail to present sufficient evidence to enable the members of the Hearing Panel to make a decision on any issues involved, then the Hearing Panel shall have no obligation to reach any conclusion whatever and the Chairman of the Panel shall submit his written report pursuant to Paragraph 21 of this Plan, designating the issue involved and advising that the Panel has deemed the evidence presented on such issue to be insufficient to

render any decision on the merits. Subject to the provisions of Paragraph 15 of this Plan, in the event that the Hearing Panel does deem the evidence presented on such issue to be insufficient to render any decision on the merits, the parties shall be deemed to have honored their commitments to be bound under the submission agreements signed by the parties and their attorneys, and shall thereafter be fully released and discharged from all commitments contained in such submission agreements. At their option, the parties may thereafter agree to resubmit their case to a Hearing Panel. If such option is exercised, the parties to the case and their attorneys shall submit new submission agreements in writing consistent with the requirements of this Plan.

13. EXPERT WITNESSES

The Hearing Panel itself shall have the power to call such experts as it, in its discretion, may deem necessary or desirable. No expert witness who is not a party to the hearing shall be permitted to testify as to ultimate issues of liability except by consent of all parties in writing at least five days before the hearing. Any party may present testimony by a consulting or treating physician who has examined the Claimant for purposes other than to appear as a potential witness in litigation, so long as such testimony does not contain opinions as to ultimate issues of liability.

14. CLOSING STATEMENTS

At the close of the presentation of evidence by the parties, the Claimant's attorney may state his resume of the evidence and its relation to the legal theories on which such evidence is based. The Respondent's attorney may then state his resume of the evidence and its relation to the legal issues relied upon by Respondent. The Claimant's attorney may then present brief rebuttal of those facts or issues discussed by the Respondent's attorney.

15. ADVISEMENT–SUPPLEMENTAL HEARINGS

When the parties present have been heard, the Hearing Panel may take the case under advisement, or it may request that additional evidence be obtained and presented to it at a supplemental hearing, which shall be set for a date and time certain, not longer than 15 days from the date of the original hearing, unless the attorney bringing the matter for review shall in writing consent to a longer period. Any second or subsequent hearing shall be held in the same manner as the original hearing, except that the opening statements of the attorneys for the parties which were given at the commencement of the initial hearing will not be permitted at any subsequent hearing. The parties and their attorneys may be present at any second or subsequent hearing.

16. DELIBERATIONS

In each case taken under advisement, the Hearing Panel shall consider all of the evidence admitted and the statements of counsel, and may also consider expression of opinions of the medical members of the Hearing Panel relating to any medical questions involved, and the legal opinions of the lawyer members of the Panel relating to any questions of law involved.

17. QUESTIONS TO BE DETERMINED

The Panel shall make its findings on the following questions:

A. Whether there is a reasonable probability that there exists a claim for relief against the Respondent based on breach of professional duty, regardless of the legal theory on which it may be predicated, and if so,

B. Whether there is a reasonable medical probability that the Claimant was injured thereby,

C. Whether the evidence presented as to questions A and B has been sufficient to allow the Hearing Panel to render its decision on the merits.

18. DAMAGES NOT ASSESSED

The Hearing Panel shall make no findings respecting the quantum of damages in the case, if any there be, and shall make no effort to settle or compromise any claim, or express any opinion as to the monetary value of any claim.

19. ALTERNATE QUESTIONS AND THEORIES

Subject to the provisions of Paragraph 18 above, nothing herein shall be construed as prohibiting the Panel from considering other areas involved or answering questions other than those stated in A and B, in Paragraph 17 hereof, in the interest of disposing of all matters which the parties or the Panel may consider relevant to the case. If the Panel, in considering its findings on Questions A and B contained in Paragraph 17 above, determines that more than one theory should be discussed on either question, the Panel may, in its discretion, include in its findings the conclusions reached by the Panel as to each theory considered.

20. VOTING

The decisions on the above three questions, and any other matters which the Panel may decide, shall be reached by a majority vote of those members of the Panel present who have attended all hearings on the issue. The Chairman of the Panel shall be a voting member in the determination of such questions, if such Chairman has attended all hearings on the issue. The votes on such questions shall be by secret ballot, and shall be tallied and announced by the Chairman of the Panel.

21. WRITTEN REPORT OF FINDINGS

Its answers to these questions shall be submitted in writing to the parties, and copies shall be furnished to the Bar Association, Medical Society, Chiropractic Association, Osteopathic Association, Dental Association, or Hospital Association Representatives concerned with the issues presented to the Hearing Panel. A copy of each report shall be retained in the permanent files to be maintained by the Bar Association Representative. The deliberations of the Hearing Panel shall be and remain secret. The written report shall be signed for the Hearing Panel by its Chairman, and shall contain only the conclusions reached by a majority of its members, provided, however, that any member of the Panel may request that his dissent from the conclusions of the Panel be noted in the official records of the Hearing Panel. The opinion reached in any case shall be treated in every respect as confidential between the Hearing Panel and their respective members on the one hand and all persons directly concerned in the case on the other. Subsequent to the written report herein referred to, to the extent practicable, the Chairman of the Panel and one medical member thereof shall meet informally with counsel for all parties to discuss the findings and determinations of the Panel.

22. CLAIMANT'S VERDICT—DUTIES

In any case where the Hearing Panel has determined that there is a reasonable probability that there exists a claim for relief against the Respondent based on breach of professional duty, regardless of the legal theory on which it may be predicated, and further finds that there is a reasonable medical probability that the Claimant was injured thereby, then the Panel and the society of the participating group whose representative has been designated as the Respondent will cooperate fully with the Claimant's attorney in procuring an expert witness qualified in the field of health care involved. Such witness shall consult with and testify on behalf of the Claimant, upon arrangement by the Claimant with said witness for payment for his services to the same effect as if the said witness had been employed originally by the Claimant. A physician, chiropractor, or dentist who has been called before the Hearing Panel in an advisory capacity or any member of the Hearing Panel shall not be precluded thereby from serving as such witness,

provided that he shall not be asked to testify concerning the evidence received or offered, or the deliberations or proceedings of the Hearing Panel, or as to any information given or acquired by him at the hearing.

23. RESPONDENT'S VERDICT—DUTIES

In a case where the Hearing Panel has determined either that there is no reasonable probability that there exists a claim for relief against the Respondent based on breach of professional duty, regardless of the legal theory on which it may be predicated, or that there is no reasonable medical probability that the Claimant was injured thereby, the Claimant's attorney shall refrain from filing any court action based upon such claim, unless personally convinced that strong and overriding reasons compel such action to be taken in the interest of his client, and that it is not done to harrass or gain unfair advantage in negotiation for settlement.

24. TIE VOTES

In a case where the secret ballot of the Hearing Panel has resulted in a tie vote either on the ultimate issue of whether there is a reasonable probability that there exists a claim for relief against the Respondent based on breach of professional duty, regardless of the legal theory on which it may be predicated, or on the ultimate issue of whether there is a reasonable medical probability that the Claimant was injured thereby, the Chairman of the Panel shall submit a written report pursuant to the provisions of Paragraph 21 of this Plan. Such report shall designate the ultimate issue on which the tie vote resulted, and shall designate the ultimate issue, if any, on which a majority vote of the Panel resulted and the answer to such ultimate issue determined by such majority vote. Upon submission by the Chairman of the written report announcing the tie vote, to the extent practicable the Chairman of the Panel and one panelist from the participating groups shall meet informally with counsel for all parties to discuss the findings and determinations of the Panel. After submission of such report by the Chairman announcing such a tie vote on one or more ultimate issues, the parties shall be deemed to have honored their commitments to be bound under the submission agreements signed by the parties and their attorneys, and shall thereafter be fully released and discharged from all commitments contained in such submission agreements. At their option, the parties may thereafter agree to resubmit their case to a new Hearing Panel. If such option is exercised, the parties to the case and their attorneys shall submit new submission agreements in writing consistent with the requirements of this Plan.

25. RECONSIDERATION

The parties or their attorneys shall have ten days from the date that the written report signed by the Chairman of the Hearing Panel has been served upon the attorneys for the parties within which to request the Hearing Panel to reconsider any issue which has been presented to the Hearing Panel for its determination. Failure to file such a request for reconsideration, specifying with particularity the issue or issues for which reconsideration is requested, within the ten days provided or within any extension of time which may be granted by the Chairman of the Hearing Panel shall cause the findings of the Hearing Panel to become final. Upon receipt of such a request for reconsideration, the Chairman shall poll the Hearing Panel and shall determine whether the majority of the members of the Hearing Panel wish to reconsider such issue. If by majority vote the members of the Hearing Panel decide that they wish to reconsider any such issue, the Hearing Panel by majority vote may reconvene for additional testimony or for additional argument by the attorneys for the parties. If such additional testimony or argument is received by the Hearing Panel, a supplemental report shall be signed for the Hearing Panel by its Chairman pursuant to the requirements of Paragraph 21 of this Plan.

26. COURT OF ACTION

It is not intended that the submission of any case to the Hearing Panel shall be considered as a waiver by the Claimant or his attorney of their ultimate right to decide for themselves whether the case shall be filed in court, except in those cases in which the parties have agreed to be bound under the provisions of Rule 109, Colorado Rules of Civil Procedure. However, any attorney who brings a case before the Hearing Panel shall weigh its conclusions in the greatest professional good faith.

1-20-76

Suggested Rewording of Questions for
Expert Advisory Panel
HB 575 Sec 09.55.536(e)(1)-(5) p5-6

(1) What was the condition for which the person sought medical care?

(2) Was the care appropriate and skillful?

(3) Is there an injury which arose from the medical care?

(4) What is the injury?

(5) Is the injury stable, or will it improve or become worse?

Members file on Malpractice

ALASKA DENTAL SOCIETY

OFFICE OF THE PRESIDENT

January 10, 1976

Mr. Langhorne Motley
Commissioner
Pouch D.
Juneau, Alaska 99811

Dear Commissioner Motley:

The Alaska Dental Society wishes to reaffirm it's position in relation to the Malpractice Insurance Commission's proposed legislation.

We object to mandatory inclusion in a joint under-writing association and adhere closely to the points and reasoning brought out in a report to the legislature made by Dr. H.S. Denenberg.

Sincerely;

Robert R. H. Sutherlin DDS

R.H. Sutherlin
President
Alaska Dental Society

cc: All legislators
All Health Care Associations
Governor
Director of Insurance

Introduced: 1/14/76
Referred: Health, Education
and Social Services

IN THE SENATE BY CROFT, KERTTULA AND RODEY

SENATE BILL NO. 507 am

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act establishing risk management in hospitals; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 18.20 is amended by adding a new section to read:

Sec. 18.20.075. RISK MANAGEMENT. (a) To be eligible for a license each hospital shall have in operation an internal risk management program which shall

(1) investigate the frequency and causes of adverse incidents in hospitals which cause injury to patients;

(2) develop and implement measures to minimize the risk of injury to patients from adverse incidents, giving due regard ...; and over

(3) analyze patient grievances which relate to patient care.

(b) The department shall adopt by regulation and submit to the legislative administrative regulation review committee prior to implementation, standards for risk management programs in hospitals in the state which may vary according to the size of the hospital, the type of care offered by the hospital, and other factors found relevant by the department.

* Sec. 2. This Act takes effect July 1, 1976.

TELEGRAM

RCA ALASKA COMMUNICATIONS, INC.
PHONE: 586-6440
JUNEAU, ALASKA 99801

Copies for Members files
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PMS TERRY GARDINER CARE HOUSE JUDICIARY COMMITTEE 1976 JAN 27 AM 10 57

JUN" 0919

AS PRESIDENT OF THE ALASKA CHIROPRACTIC SOCIETY
I HAVE BEEN DIRECTED BY ITS MEMBERS TO REQUEST
YOUR ASSISTANCE IN EXCLUDING (TOTALLY)DOCTORS
OF CHIROPRACTIC FROM SB522 MALPRACTICE CLAIMS ARE NOT
A PROBLEM WITH OUR PROFESSION AND OUR MEMBERS ARE
ADEQUATELY INSURED THROUGH OUR NATIONAL CHIROPRACTIC
AS ORGANIZATION FOR OUR PATIENTS PROTECTION

CECIL S MCLEOD DR

1. Dept of Rev be obligated to make investment

~~F~~ to Corp. - certification of fund deficiency by Director of Div of Insurance to Com of Revenue

Be able to

"private group" + "hospitals"
"private clinic"

Sec. 21.88.080. REQUIRED INSURANCE; CANCELLATION. The corporation shall provide insurance to all health care providers otherwise eligible for licensure under AS 08.64 and AS 18.20. The corporation may provide for installment payment of premiums in which event each installment is due by the date specified. The corporation may cancel any of its policies in the event of nonpayment of any premium or installment on a premium or other charge by mailing or delivering to the insured at the address shown on the policy and to the agency of the state issuing the insured's license written notice stating when, not less than 10 days after notice is received by the insured, the cancellation is effective.

ARTICLE 3. LOAN FUND.

Sec. 21.88.110. FUND ESTABLISHED. (a) There is in the Department of Commerce and Economic Development a medical malpractice liability revolving loan fund to be administered by the director of insurance.

(b) Loans from the fund shall may be made to the corporation when necessary for the ~~fund~~ Corporation to maintain adequate reserves.

(c) Loans from the fund shall be repaid by the corporation within four years at an annual interest rate of seven per cent.

ARTICLE 4. GENERAL PROVISIONS.

Sec. 21.88.300. DEFINITIONS. As used in this chapter,

(1) "corporation" means the Health Care Providers Indemnity Corporation;

(2) "director" means the director of the division of insurance for the State of Alaska;

(3) "fund" means the medical malpractice liability revolving loan fund;

(4) "health care provider" means a physician licensed under AS 08.64 and a hospital as defined in AS 18.20.130, including a hospital [illegible] state facility owned or operated by the state or one or more of

its political subdivisons;

(5) "occurrence basis insurance" is insurance against claims arising during the period of the policy coverage.

* Sec. 24. AS 08.64.365 is repealed.

* Sec. 25. This Act takes effect 30 days after enactment.

Alaska State Legislature

REPRESENTATIVE
TED SMITH
2616 SORBUS CIRCLE
ANCHORAGE, ALASKA 99504

WHILE IN JUNEAU
POUCH V
JUNEAU, ALASKA 99811

COMMITTEES
RESOURCES
BUDGET & AUDIT
LABOR & MANAGEMENT

House of Representatives

February 10, 1976

Terry Gardiner
Chairman
House Judiciary

Dear Terry,

These comments are directed to the Work Draft Copy of CSHB 574 marked 2nd Version of Draft #2.

Sec. 18.20.075 starting at line 23 on page 16 deals with risk management. I recommend that this be changed to loss management and be a function of the Health Care Provider Indemnity Corporation. Many of the functions listed are already accomplished and/or provided for under the provisions for review organizations starting on page 17. It should be a function of the HCPIC to provide professional expertise to its insureds in the area of lost prevention.

The definition of function of a review organization on page 21 under Sub. Sec.(H) includes acting as an arbitrator or mediator. Some of the immunities provided to the review organizations are not appropriate in this context. Specifically I do not believe that the privilege of confidentiality in a physician-patient relationship should be waived for this function. Accordingly I recommend that on page 17 at the end of line 21 you add the phrase "except a review organization acting under authority of Sec. 70(5)(H) of this chapter." I also do not believe that the immunity from discovery is appropriate for such organization and on page 19 after line 13 I recommend that you add the following:"(d) The immunities of this section do not apply to a review organization acting under Sec. 70(5)(H) of this chapter."

It is my understanding that the remainder of the bill starting on page 22 does not express committee intent so I will withhold comment on that portion of the bill.

Sincerely,

Ted Smith
Chairman
House Labor & Management

TS:hk

Representative Gardner,

Comment on C S - Bill 574
by the House Judiciary Committee.

Our first reading is favorably impressed by the many good features.

We would like to suggest that one very important factor it needs and which would strengthen it considerably - to make insurance companies & their cost more predictable is a strict Statute of limitations as in Indiana - see attached copy.

Such statute of limitations would make a "late Claims fund" unnecessary. In the absence of this type of statute of limitations - then a late claims fund becomes more needed.

Thanks.

R. Witt, MD.

Indiana – April 2, 1975 (Reprint)

or his insurer to or for the plaintiff, or any other person, may not be construed as an admission of liability for injuries or damages suffered by the plaintiff or anyone else in an action brought for medical malpractice.

Sec. 4. Evidence of an advance payment is not admissible until there is a final judgment in favor of the plaintiff, in which event the court shall reduce the judgment to the plaintiff to the extent of the advance payment. The advance payment shall inure to the exclusive benefit of the defendant or his insurer making the payment. In the event the advance payment exceeds the liability of the defendant or the insurer making it, the court shall order any adjustment necessary to equalize the amount which each defendant is obligated to pay, exclusive of costs. In no case shall an advance payment in excess of an award be repayable by the person receiving it.

Sec. 5. A patient's claim for compensation under this article is not assignable.

Sec. 6. Financial responsibility of a health care provider under this chapter may be established only by filing with the commissioner proof that the health care provider is insured by a policy of malpractice liability insurance in the amount of at least one hundred thousand dollars ($100,000) per occurrence.

Chapter 3. Statute of Limitations.

Sec. 1. No claim, whether in contract or tort, may be brought against a health care provider based upon professional services or health care rendered or which should have been rendered unless filed within two (2) years from the date of the alleged act, omission or neglect except that a minor under the full age of six (6) years shall have until his eighth birthday in which to file. This section applies to all persons regardless of minority or other legal disability.

Minor
In jail
In military service
Mentally incomp

Sec. 2. Notwithstanding the provisions of IC 1971, 16-9.5-1-7, any claim by a minor or other person under legal disability against a health care provider stemming from professional services or health care rendered, whether in contract or tort, based on an alleged act, omission or neglect which occurred prior to the effective date of this article, shall be brought only within the longer of

(a) Two (2) years of the effective date of this article, or

(b) The period described in section 1 of this chapter.

Chapter 4. Patient's Compensation Fund.

Sec. 1. (a) There is created a patient's compensation fund to be collected and received by the commissioner for exclusive use for the purposes stated in this article. The fund and any

Additional Coverage Made available
Excess / Coverage

States full faith & credit

~~Page 22 line 20~~

Page 23 — statistics
Provisions for Suit info to go to licensing Board

Page 24, line 25

include Retroactive portion

check required reserves requirement
Commission Recommendation said
retrospectively lower premiums in future

Page 27, line 12 - check "indemnifying"

→ allow both retrospective adjustment
+ returning premiums

2 years

Plaintiff

- Informed consent
- Continuing Education
- Risk Management SB 507
- clearing + convincing

Yes

Yes

Medical Board set standards
4 year time period
Subject to reexamination if not complied

1. additional assured by Hosp.
language Page 51, line 21

Check Court Rule change on
Discovery Clause page 19

Cause of Action for triggering mechanism

N ☐ 400,000
500,000

Chris Beardsley - Providence

20,000 for $20 million coverage
increased cost under M.I.C.

Bar Assoc Endorse } Court ?
AMA Endorse } Approve

~~Endorsed~~

Require MIC to contract to
— Per Diem
Page 21, line Retro-active clause

Page 22 (6) umbella language - does it make sense

Pending Contingent liability

Rewrite fund for Revenue not Appropriation

Reasonable Rates for fund in Gov bill

Mechanism on Doctors Rates for New ones

Hospital Insurance Rate Determination

Page 21 line 8 ? why this

Page 21 (b) rewrite

Mandatory section on Management of MIC





Experts in Medical Mal/Practice Risk Management

allow internal Risk Managers To impose

Introduced: 1/14/76
Referred: Health, Education and Social Services

IN THE SENATE BY CROFT, KERTTULA AND RODEY

SENATE BILL NO. 507 am

IN THE LEGISLATURE OF THE STATE OF ALASKA

NINTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act establishing risk management in hospitals; and providing for an effective date."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

* Section 1. AS 18.20 is amended by adding a new section to read:

Sec. 18.20.075. RISK MANAGEMENT. (a) To be eligible for a license each hospital shall have in operation an internal risk management program which shall

(1) investigate the frequency and causes of adverse incidents in hospitals which cause injury to patients;

(2) develop and implement measures to minimize the risk of injury to patients from adverse incidents; and

(3) analyze patient grievances which relate to patient care.

(b) The department shall adopt by regulation and submit to the legislative administrative regulation review committee prior to implementation, standards for risk management programs in hospitals in the state which may vary according to the size of the hospital, the type of care offered by the hospital, and other factors found relevant by the department.

* Sec. 2. This Act takes effect July 1, 1976.

1

1. Socialized Medicine
2. State fund Docs contribution
3. State trust fund - people pay
   A. limit docs liability 100,000

John Ale

			New
58-152	Commissioners	—	28-58
3	Boards & Bureaus		~~1~~ 2
	Administration		
	legal (ratify & dismiss Michigan)		Some
	Advisory panel		Unpredictable
	Reserves for future		

(1) 1974 5,000 av. 300 docs 1.5 million premium

(2) Scale of doctors incomes

(3) Breakdown of premium dollar
St. Paul ~~&~~ Aetna

(1.) What % of Alaskan cases go to court

(2) ~~W~~ How many cases for plaintiff in jury cases

What's trial de novo

~~B~~ 40 - defense expense of litigation
12 - plaintiff
12 - broken
17

to difficult to refute expert testimony

impartiality & credibility is strength of Advisory Board

1st./claims Made - Single fund

Premiums based on gross receipts

70% of doctors pay 1,000 or less

9% of doctors pay high risk

Only 5% of claims are ever actually are filed

Att won't take cases unless case a minimum cost of #10,000 out of pocket expenses

Why less in front of Adjudication Board

1. & Expert Advisory Board reduces costs because of their expertise & credibility

1. Selection of jury - 2 days
2. instruction of jury - ½ day
3. presenting evidence to jury - complicated

Never been jury award against doctors

W

≤8% of cases settled out of court

Justification for state Participation

1. ~~(1)~~ insurance Co. have such low surpluses they can't buy any insurance anyway

(2.) Only operates in state will be interested because they are captive and subject to JUA

(3.) Insurance co. have had bad experience with Malpractice and would be very conservative in any bid + high risk - want high profits

(4) Cheaper Cost because no profit required by state
15% for insurance co.
+ additional savings of Commission etc. in proposed MIC

(5)

1. limit contingent fees
2. eliminate ad Damnum clause - in bill?

Denneberg

1. Consumer on Boards in bill?

2. Ohio & Wisconsin continuing education
have Rick get these
give more authority to Board?

3. Florida set up internal Risk management
procedure - Com. recommendation
set aside 10% of premiums to fund this?

Working Committee
1. Block
2. Smith
3. Carpenetti
4. Rob Koshas ?
5. Rick

Malpractice

Ins. ~~Incr~~ payments

Legal – losing att pay fees

Medical – dispiriary

Ask Block – about losing Att pay fees
Talk to Malpractice Att in Calif
Dennenberg
College Legal Prof

Suits are winning ! therefore would anything discourage good suits ?

What % of suits filed win anything ?

~~" " " losing suits~~

What do ins Co. pay out in suits they ~~lose~~ win in terms of legal and defense costs

Is SB113 contained in Gov. package

Contract Co. to Manage & Write policies
to do paper work Similar to Alaska U.F. Grp.
1. policy % of income
2. premium gaged to experience ± 10% (example) – Mechanism to space over years in increase – excess in reserve fund to build up – State to invest state loans etc.

put in reserve fund until education program developed of do both education – loss control State Medical education program & ~~&~~ on going

Can you write one standard policy

1. Alt to admit other groups by com.
   but only if all of group joins

Premiums include ① cost of program - go to gen fund
② losses
③ reserve
④ Education fund

state sets standards of policies as set by advisory bd of group insured - use ~~staff~~ existing licensing bd

~~So~~ Bradley Bill $5 million to set up fund to be paid back to general fund over ~~10~~ 10 years at 7½% - Dir of Ins can suspend to insure solvency of fund

add = employees to Division of Ins to Manage

1 Part
2. Cotton

deduct costs of state

1. state ins plan : Ass does by gross income
2. ~~losing~~ att pay court costs - provide exception
3. State Medical care
4. Policing of Doctors

~~att can only charge on hourly basis~~

Save Money of administering program

1. total premiums paid in Alaska now
2. average Mal practice settlement now
3. State funds paid for State Medicare
4. Cost of state administration of Ins.

III set up adjudication board to cut systems cost

breakdown of premium dollar

Medical Malpractice

Act Snowden

1. Adjudicatory Board
2. Advisory panel ~~to~~ Superior Court

No. 7 recom.

difficult to administer Adjudicatory

→ Was submitted as a court rule change

Dr. Wilson - Advisory Committee

Rejection of Advisory panel concept by Supreme Court will be outlined in letter

Statistics

'66 Malpractice suits 18 years
3.7 suits per year
2.8 million payed in settlement
500,000 settlement in 1974

Because 100 of 370 insured less suits ?

13-~~25~~¢ of premium dollar goes to

Roy Box Optometrist

Umbrella insurance available

SVA - disadvantage - tax on insurance companies therefore all consumers in Alaska

MIC - take advantage of re-insurance experience & expertise on Mal-practice

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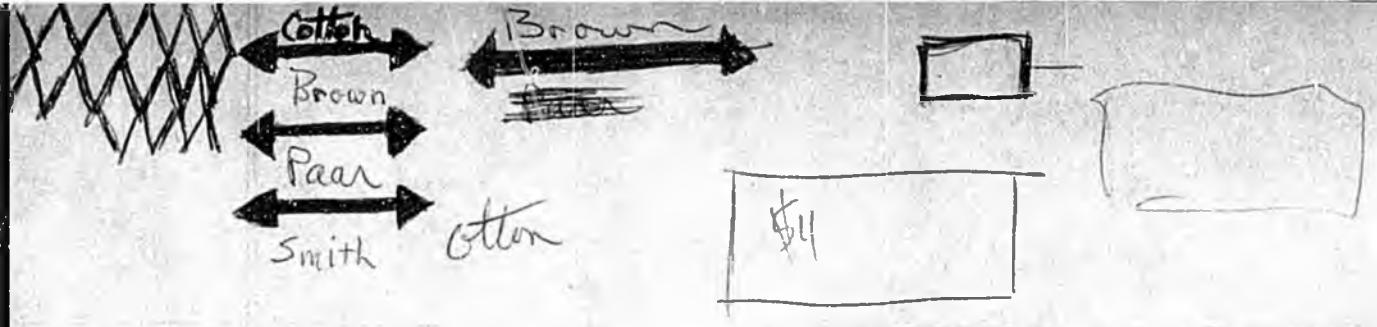
Late Claims Fund

statute of limitations (2 year) doesn't apply

no personal liability with the fund

thus allows more recovery

higher burden of proof though



Insurance Co. don't care what the experience is in Alaska

AIPAC - "Hale" $5 million capitalization

Feb 11 - Reinsurance People

(1.) No History on Alaska - Don't believe we have a problem

(2.) Patients go out of state for treatment
Who is responsible

Insolvency pickup problems - other ~~cancel~~

Dollar Volume of Claims - 90% payment in 1st 3 years.

Inclusion of other groups - Nurses etc
1. Cut cross complaints - Multiple defendants
common defense
2. different rights for different folks
3. Concern for how each other function in health care system.

" include Medical Health Care Group "

Cost (1.) Continue existing occurence rates
SUA has to be self supporting
" retrospective adjustment "

AS 8.64.107 - .366 limitation of liability

MIC - ~~Title~~ Insurance Co. don't have surpluses to write and pick up our insurance

Dick Block

1. Controllable Progam - control cost
transfer uncontiolable risk to someone else

OCCURENCE - never used to be a problem

1974 - Stock Market crash
up to 1972-1973 lucrative insurance profits
Made a lot of investments in stock market
∴ lots of $ lost
At the same time high Medical care inflation
Companies didn't sell stocks instead drove
surpluses down — ∴ cut back premiums

Get NAIC Report

50% come in 1st year claims
later claims are big ones

excess costs in Alaska because 5 programs
spread over 315 doctors

Adverse selection if not Mandatory inclusion

Plan 1 1. Mandatory — exclusive; controllable program
Plan 2 2. Now ready to sell insurance through MIC
each years calculations of ratio passed on to
next years rates - MIC not Mandatory

Plan 3 Back up SUA

Plan 4 Late Claims Fund - don't collect
- some Medic on Cash basis

Insurance
Medical
legal

Medical Mal-practice

1. overall cost is uncontrollable (legal reduced)
2. mechanism for spreading cost is inefficient

1-13 recommendations - legal control cost

liability system 40%-60% → distribution to individual
other collateral system 85%-95% → " " "

Separation of speculative cost to control cost of insurance

Recom 12 - Pay for damages periodically

9+10+11 - Adjudication Board — small claims aren't being paid of filed

23-27 - Prevent Malpractice from occurring

13-23 - Distribution of Cost.

(1.) By including all physicians you actually include all patients

(2.) Indemnity Corp needs all members to function

One source for Ins & Private Ins can manage program better than State

Because of controllable Cost in 1-13 Indemnity Corp will be able to find ins. in private sector

Stand By facility - JUA

Late Claims fund - No obligation for 3 years

Enforcement Mechanism - doctors all belong to insurance pool



1st 3 years you can quantify/cost

94% of Claims in 1st 3 years

Robert Whaley - Alaska State Medical Assoc

1. No longer have radiation service in Alaska
2. losing some experts
3. Ultra-conservative in attitude of risk

No-fault coverage - commission didn't feel appropriate

Agree with Den. recommendation on strengthening Comm.

2/3's of cases 1. wrong choice 2. bad luck

Ask what Medical Assoc pos on all phys. being included

Blue Cross - John Hopkins
support commission proposal even though has SUA

Dr. Kim Fairbanks
240- of 300 belong to competet groups.

100 physicians without insurance today

Blocks - Calif broker for hosp Assoc.

set aside $700,000 instead of $4 million per periodic payment - this is the savings

---

Henry Pratt - opposed mandatory inclusion
Dentist insurance is National + includes all kinds of coverage

Vic Dunbar - Hosp Assoc.

two exceptions
1. #14 Mandatory inclusion
2. #22 All Health Care Providers

Assoc. split on this issue

Joe Josephson - Alaska Medical Assoc.
Use Commission bills as a base

1. discipline
2. retroactive coverage - ask Dick Block

AMERICAN MEDICAL

JANUARY 12, 1976

Physicians' liability protest widens in Southern California

With the holidays over, hospitals in Southern California began to feel the full force of a work slowdown by physicians protesting increasing professional liability insurance premiums.

A check by the Southern California Hospital Council of the 160 hospitals in Los Angeles County showed 64 had experienced some restrictions in services by Jan. 5. Elective surgery had been cut back in all 64. Effected to a lesser degree were obstetric-gynecological procedures, emergency room services, and outpatient care.

Hardest hit was the northwestern area, in Encino and the San Fernando Valley, where 20 out of 30 hospitals reported slowdown actions. Almost all orthopedic and neurosurgical services were halted there. Only eight Southern California hospitals outside Los Angeles County were affected. The job action, however, was expected to continue to build.

IN RESPONSE to the survey, the Los Angeles County Medical Assn. activated its 24-hour referral service on Jan. 6 to help patients needing medical care.

Meanwhile, a last-minute proposal by the governor's office submitted on Dec. 29, was turned down by the medical societies and other physician groups, although parts of it may be salvagable.

The plan, "California Malpractice Reform Act of 1976" would establish a physician-controlled fund to pay claims.

Florida hospitals yield on insurance rules, page 10

Average cost to physicians would be $4,000—one-third more than average 1975 rates, but considerably lower than newly proposed increase.

The catch is that physicians could no longer refuse to treat Medi-Cal patients. MDs with less than 10% Medi-Cal patients also would have to provide up to 20 days of free services annually. The plan also would require the medical profession to operate a "peace corps" in the underserviced areas of the state.

California Medical Assn. (CMA) governing council, meeting in special session Jan. 5, endorsed only those parts of the plan not dealing with the "peace corps" or Medi-Cal treatment. Those portions approved include a limit on physician liability and a check on legal merits of a suit before it can be filed.

The council also voted to support actions of physicians involved in the slowdown. It called for reforms that would establish compulsory arbitration, screening panels, and "specialty courts" for malpractice claims; allow filing of counterclaims; eliminate pain and suffering awards; provide a schedule of awards in wrongful death actions; grant absolute immunity for physicians rendering emergency care and for those on peer review panels; and set up a catastrophic health insurance plan for all Californians.

LATER THAT EVENING, the Los Angeles County Medical Assn. council

(See Liability . . . , p. 10)

Liability slowdown widens in California

(Continued from page 1)

agreed to back up the CMA recommendations on the administration's plan. Agreement between the two societies may signal a halt to the infighting that has characterized the liability dispute in recent months. Members of the various splinter groups that have criticized organized medicine also have indicated during meetings with the societies they will begin to coordinate efforts aimed at halting runaway premium costs.

The 327% increase in premiums, scheduled to go into effect in Southern California on Jan. 1, has been delayed at least for a month, although it may be made retroactive. The company plans to appeal the decision against its requested 486% increase and will put off billing physicians until next month. It has assured physicians in the plan that they will be covered during that time.

Survey shows liability law gains in '75

An *American Medical News* survey of the country's medical societies indicates that during 1975, at least 31 states approved legislation aimed at controlling the crisis in medical liability.

As a result of these activities, availability of insurance is no longer a serious problem in many areas. Some 20 states passed laws allowing for formation of a pooling mechanism, such as a joint underwriting association, or of a physician-owned insurance company. Sixteen have put those pools into operation; seven have physicians' companies.

Premiums, however, continue to escalate, with little relief in sight. Physicians in at least 13 states experienced premium increases of 100% or more and another five reported increases beyond 500% during 1975. One exception to this is Indiana, first state to approve sweeping regulations on malpractice claims. Physicians there received only a small increase during the year, and may have no increase during 1976.

A type of patients' compensation fund, similar to that passed in Indiana, was approved in four other states, and seven medical societies hope to interest their legislators in the legislation during the coming year. The system generally sets a limit on physicians liability and establishes a fund to pay costs beyond that amount.

Seven states approved a limitation on awards and 15 more will try to do this during 1976, although the constitutionality of such laws is being disputed.

Attempts to police the medical professional have led nine states to strengthen their boards of medical examiners; nine more plan to introduce similar measures during this year. Two states, Washington and Wisconsin, approved continuing medical education requirements, and Minnesota hopes to have this passed in 1976.

Details on each state's situation appear on page 13.

Survey shows gains in liability legislation, but problems remain

Alabama

The Alabama Medical Liability Act was passed in September, 1975. It provides for a statewide JUA, reduces the statute of limitations, repeals the ad damnum clause and establishes a malpractice claims reporting system. There are no plans for further legislative action in 1976.

According to the Medical Society of the State of Alabama, physicians are not having difficulty getting coverage. However, the society-sponsored carrier, Wausau, has expressed a desire to terminate its activity in July. The society says it is in the initial planning stages of a physician-owned insurance company. According to a society spokesman, the incidence of claims reported in the last year has increased 75%. Premiums have increased approximately 50%.

Alaska

Alaska physicians continue to experience a serious problem with availability of coverage. New policies are available only through the medical society plan with Mutual Fire, Marine, and Inland, which writes only claims-made policies up to $300,000 limits. A July survey by the medical society showed that 22% of physicians had no insurance and 40% had unsatisfactory coverage. Delivery of care has been seriously affected. Many patients have had to travel to other states for treatment.

The legislature has approved a joint underwriting association, but the plan was vetoed by the governor who has established a committee to investigate alternatives. The medical society favors a state-run pool to guarantee coverage. Family practitioners covered by Mutual Fire and Marine had premiums increased from $400 to $6,000; rates for orthopedic surgeons went from $2,000 to $12,000.

Arizona

The state will lose its only carrier, Travelers, on April 1, when the company terminates its program with the medical society. Before then, the society hopes to have legislators approve a temporary joint underwriting association and physicians' mutual company. It also is working with the hospital and bar association on various reforms modeled after Indiana's Patient Compensation Fund. Travelers received a 107% increase this year, putting premiums at between $1,595 and $9,119 for $1-million limited coverage. The Insurance Service Office has recommended rates in the state be raised an average 300% during 1976.

Arkansas

The Arkansas State Legislature passed during its 1975 session legislation that makes mandatory the reporting of all claims filed to the medical examining boards, sets up a JUA, and establishes a voluntary arbitration panel whose results are admissible in court as evidence. Since the legislature only meets every other year, there is no legislation on the agenda. However, according to a medical society spokesman, efforts to amend the state's constitution will begin to clear the way for legislation similar to the "Indiana package."

Liability coverage is available in Arkansas, if a physician accepts St. Paul's claims-made policy. St. Paul is the state's only carrier. Premiums have increased a total of 80% over the last year. Society officials say there has been a "marked increase" in the number of claims filed against physicians.

California

Legislation passed following a month-long job action in mid-1975 includes a limit on awards for pain and suffering, sliding scale for contingency fees, strengthening the board of medical examiners, and a reduced statute of limitations. The mechanism is available for a joint underwriting association, and mutual companies have been formed in the San Francisco area, in other parts of Northern California, and in the Los Angeles area.

None of these measures, however, promises any effect on the soaring costs of premiums that increased up to 327% in parts of Southern California on Jan. 1. Northern California MDs received increases of 341% on Nov. 1 last year. High-risk physicians pay $36,000 in the south and $22,000 in the north for coverage of up to $1 million/$3 million.

Colorado

No malpractice legislation was passed in 1975. For the coming session, however, the medical society and other groups have made it known that there will be a number of bills submitted. A society spokesman says that the society's bill will address itself to the statute of limitations and strengthening the Board of Medical Examiners. Groundwork for a JUA is expected to be laid.

Availability of insurance does not seem to be a problem. The society-sponsored carrier, Hartford, is the predominant carrier in the state, and Empire and St. Paul also are active. Premiums have, as elsewhere, been on the rise. As of last June, the premium on policies offering $100,000/$300,000 coverage has risen 15%. $1-million coverage has increased 40%, while $3/$5-million coverage has increased 39%. A medical society official said 44 claims were filed last year, 38.9% more than a year earlier.

Connecticut

With 90% of the state's physicians covered by Aetna Life and Casualty Co., Connecticut reports there is no problem in obtaining adequate coverage. However, the number of liability cases by specialty more than doubled from May 1, 1974, to May 1, 1975, prompting a 40% increase in premiums.

Although the state medical society has no plans to start a JUA or physician-owned company and although there was no remedial legislation passed in the past year, the society will pursue a broad legislative program in 1976, including sliding contingency fees, a ceiling on awards, and a study of arbitration.

Delaware

When the Delaware General Assembly convenes Jan. 13, the Medical Society of Delaware will push for tort reform, limitation on awards, and creation of a JUA. It does not intend to create a physician-owned firm. The medical society reports its agreement with Aetna, which insures about 70% of the state's physicians, has one year to run, and that, "For now, physicians who are our members can still get insurance—for a price."

During the past year, premiums in Class I increased 66.7% and the Class III premiums jumped 74.8%. The society said it could not ascertain if there had been an increase in the number of claims.

District of Columbia

The medical society plans to continue to work on several bills introduced but not passed last year, which include a $500,000 limit on awards, establishment of mandatory review panels, and a reduction in the statute of limitations. It also is working with the insurance commission on plans for a joint underwriting association, although availability is not a problem at this time.

Coverage is available through the society-sponsored plan with Hartford, now in its third year of a five year plan. St. Paul and U.S.F. & C. also write policies. Hartford received an 83% hike in premiums during 1975. Coverage on $1-million/$3 million policies costs between $200 and $1,000. The society, however, predicts a significant jump in rates this year.

Florida

The Medical Malpractice Reform Act of 1975 established in Florida a mandatory mediation panel—now being challenged for its constitutionality in a Florida court — and a statewide JUA. Further legislation concerning medical liability is expected in 1976, particularly in the area of tort reforms. The Florida Medical Society-sponsored insurance trust, which offers $500,000 basic liability coverage for the same rates Argonaut charges for $100,000 coverage, has attracted over 4,000 participants.

A society spokesman told *AMN* that during the period of 1963-74 the rate of claims filed rose from 3 per 100 physicians per year to 16 per 100 per year. Under the JUA, the premium for basic coverage for a Class I physician in Dade and Broward County, for example, is $2,930. For a Class V, it is $24,247. Under the trust (claims-made), a Class I doctor pays $1,313 and a Class V pays $8,243.

Georgia

Georgia's legislature in 1975 passed a law that permits the insurance commissioner to set up a joint underwriting association, if and when physicians are no longer able to get liability coverage.

For the time being, the state's physicians have no trouble, except in getting excess coverage over $1 million. Some 95% of the state's physicians are insured under the Medical Assn. of Georgia's program with St. Paul, on a claims-made basis, and overall premiums were actually reduced this year by 11%. Malpractice claims this year are up 40%, but many of these are nuisance claims generated by publicity, say medical association officials.

Hawaii

A feared Jan. 1 pullout by the major carrier, Argonaut, was postponed pending legislative action. The medical society is working with the administration to develop an omnibus bill containing various tort reforms. A joint underwriting association, not favored by the society is available to physicians should the need arise.

Rates increased only 11% for basic coverage and 13% for excess coverage last year. Physicians now pay between $668 and $4,343 for $25,000/$75,000 coverage and between $1,046 and $13,010 for $1 million. The incidence of claims rose sharply in 1974 and again during the first part of 1975, but dropped off the second part of last year.

Idaho

The Idaho state legislature passed in 1975 the Hospital-Medical Liability Act, which placed a limitation on liability and created a statewide JUA. The concept of limiting liability has since been tested in the courts and found to be unconstitutional and some have questioned the constitutionality of JUAs. Because the Liability Act was a non-severable bill, many of the other items that were passed along with the JUA and liability limitation clauses will be reconsidered during the 1976 legislative session.

Coverage is available. When Argonaut, which covered 500 of the state's physicians, pulled out last year, St. Paul, with its claims-made policy, stepped in. On Aug. 1, the Insurance Service Organization recommended companies in Idaho institute a 287% across-the-board premium increase. According to a spokesman for the Idaho Medical Society, a feasibility study is under way to consider the possibility of a physician-hospital-owned insurance company.

Illinois

The Illinois Supreme Court will decide this month the constitutionality of two new laws—a limit on awards and mandatory screening panels. Legislators also approved a lowered statute of limitations and provided the mechanism for a joint underwriting association during 1975. The medical society plans for 1976 include various tort and judicial reforms.

Physicians have no trouble obtaining adequate coverage through one of eight carriers in the state, including a society-sponsored program with Hartford. Premiums rose an average of 49% to 69% during the past year, putting premiums at between $368 and $5,084 in the Chicago area, and between $344 and $2,868 in the less populated areas for $100,000/$300,000 coverage. Claims rose 42% last year in the Chicago area.

Indiana

In April legislators approved a precedent-setting measure that established a $100,000 liability limit on physicians, a catastrophic fund to pay awards beyond $100,000 up to an additional $400,000, a risk manager system to guarantee coverage, mandatory screening panels, a limit on attorneys' fees, and a shortened statute of limitations. During 1976, the medical society plans to seek revision of portions of the law, such as adding a $100,000 limit on cases involving more than one physician, and possibly legislation allowing individual physicians to insure themselves.

Medical Protective of Ft. Wayne, insurers of 52% of the physicians, did not seek an increase during 1975 and likely will not do so during the first part of 1976. Rates of other firms—Aetna, Hartford, and Continental—went up 18% in September. A pull-out by major carriers has halted; only St. Paul, which insures 200 MDs, will leave. A few physicians are covered by the risk manager system, whose rates range from $1,629 to $13,250. Medical Protective charges between $508 and $3,269 for $100,000/$300,000 coverage. Other firms charge between $822 and $6,913.

Iowa

Laws enacted during 1975 to establish a joint underwriting association, define informed consent, allow the courts to rule on contingency fees, and reform other torts laws were just a beginning, according to the state medical society, which plans to press for passage of an eight-point package during the year. Included would be a possible limit on physician liability plus a state fund for excess awards, a ceiling on awards for pain and suffering, a system for arbitration, strengthening of the board of examiners, and other tort changes.

Basic coverage is available, at rates ranging from $621 to $3,825 for $200,000/$600,000, but excess protection is difficult to obtain. Coverage is available with Medical Protective; St. Paul, which writes only claims-made; and Aetna. Older physicians, however, especially those with claims against them, are often not renewed.

Kansas

Only one law on liability passed the legislature last year; it required insurance companies to report claims. The medical society plans an extensive campaign for 1976 in attempt to get approval for an Indiana-type compensation fund that would limit liability to $100,000 and establish a fund to pay excess awards up to $500,000. Plans also call for voluntary arbitration, screening panels, revising the board of medical examiners, and establishing a temporary JUA.

Insurance now is available to most physicians, but at high costs that vary greatly. Basic coverage for Class I ranges from $500 to $2,000 and for Class V from $3,000 to $6,000. Carriers include Medical Protective, which writes 55% of physicians; St. Paul, which writes 35%; and Aetna and Hartford.

Kentucky

The Kentucky legislature did not meet last year. This year, it will consider reforms recommended by a governor's task force, among them a type of JUA.

Insurance is available to physicians through Medical Protective, which writes 65% of policies, Aetna, which writes 15%, and other companies. Some new physicians have experienced difficulties obtaining coverage. Rates increased last year about 60% to between $1,823 and $3,304 for $100,000/$300,000 coverage. Incidence of claims rose 33%.

Louisiana

A package of reforms based largely on the American Medical Assn.'s model legislation won approval in 1975. These include a $500,000 limit on awards, contractual binding arbitration, informed consent definition, and a shortened statute of limitations. Also approved was a limit on physicians' liability of $100,000/$300,000, and a patients' compensation fund to pay awards for over that amount up to $500,000. The medical society has opposed either a JUA or a mutual company, although coverage may soon become a problem as Hartford, which covers 75% of physicians, continues to cancel some physicians.

Most of the remaining physicians have insurance through St. Paul, which will not write new policies. Rates increased 91% in July and went up another 75% this month. Premiums for $100,000/$300,000 coverage cost between $695 and $5,247. The medical society estimates the number of claims rose 300% last year.

Maine

Reporting its premiums increased "too much" (from $400 to $1,800 annually for some internists; from $1,600 to $4,000 for the higher-risk specialties), the Maine Medical Assn. sponsored 1975 legislation for creation of a JUA and formation of a malpractice study commission.

Both were adopted, and the society now awaits the commission's recommendations to plan its 1976 legislative program.

Coverage is difficult to obtain only for new physicians, those who are foreign-trained, and those who have suits pending. The society has no plans to start its own company, and reports it has no way of obtaining data on claims filed.

Maryland

In 1975, the legislature in Maryland passed bills which established a JUA, changed the statute of limitations to three years from discovery, and provided for the creation of the society-sponsored Mutual Liability Insurance Society, which went into existence June 1, 1975, and has been writing policies since July 1. A governor's task force is looking at other proposals which come before the legislature in 1976.

At present, Hartford Insurance Co., is the only carrier that continues to renew policies. Other companies have withdrawn and are no longer renewing policies. No company is accepting new risks. Premiums have been rising; Mutual Liability Insurance Society's have risen 200%.

Massachusetts

The legislature enacted a joint underwriting association programmed to self-destruct by the end of 1977. To date, the JUA has written policies on 900 physicians; coverage is available up to $1 million/$3 million.

Legislation supported by the medical society also established a study commission to review the tort system and recommend changes, and established a medical screening tribunal and medical disciplinary board. The medical society is studying the feasibility of establishing a captive company to insure its members.

Michigan

Last year, laws allowing binding arbitration, a shortened statute of limitations, immunity for peer review board members, extension of the Good Samaritan Act, establishing a state insurance pool, and requiring insurance companies to report claims were passed. This year, the medical society would like to see considered a limit on awards, further shortening of the statute of limitations, and provisions requiring all suits to have an affidavit of merit. The Brown-McNeely state fund has been activated with rates at about $2,000 to $12,000 plus surcharge. It covers some 1,500 MDs.

Medical Protective writes about 65% of physicians' policies and charges between $1,185 and $7,863 for $100,000/$300,000. The company received a 126% premium increase in October. Both St. Paul and Shelby Mutual are leaving the state. Excess coverage generally is not available in the state. The society hopes to have its required $3 million in capitalization collected within the next few months so it can begin issuing policies for its mutual company.

Minnesota

The state society is recommending a legislative package including: reinstatement of the collateral source rule, strengthening the policing powers of the state board of medical examiners, continuing education requirements for relicensure, and tort reforms.

St. Paul, which insures 90% of the state's physicians in a program based on an agreement with the society, switched to claims-made this year, so some of the low-risk groups experienced a decline in premiums. Any large jumps will come in subsequent years.

St. Paul projects 348 claims for 1975, based on midyear statistics; 305 claims were filed in 1974; 199 in 1973.

Mississippi

Mississippi physicians have had no liability premium increase this year—though all policies are now on a claims-made basis, since the only carrier in the state is the medical-society-sponsored plan under St. Paul.

Physicians have as yet had no trouble getting new coverage, and comparatively few malpractice suits have been filed (80 this year, compared to 60 last year). However, the Mississippi State Medical Assn. is backing a nine-part reform package to be introduced in next year's legislature, including screening panels and a joint underwriting association.

Missouri

In 1975, the legislature approved a law allowing the medical society to form a mutual insurance firm. This year legislative plans include measures to control contingency fees, establish a JUA, increase the powers of the licensing board, establish review panels, and provide numerous tort changes.

The state still has several carriers, but only one or two write new business. The medical society has formed Missouri State Medical Insurance, Inc., a for-profit insurance firm that writes about 400 policies. Rates range from $500 to $30,000 for $100,000/$300,000 coverage. Medical Protective, which insures 50% of physicians, received a 50% rate increase in October. Other carriers' rates went up 300% to 400% last year. The Insurance Service Office has recommended another 100% increase for this month.

Montana

The state legislature did not pass any liability measures in 1975 and will not meet at all this year. The medical society has established an ad hoc committee to consider future changes in tort laws.

Aetna writes 80% of policies in the state through the medical society and St. Paul covers others. Premiums increased 72% during 1975 and will go up another 76% this month. Class I physicians pay $1,560 and Class V pay $13,270 for $1 million coverage.

Nebraska

The medical society plans to introduce legislation in 1976 patterned to some degree after legislation passed this year in Indiana. It will include a medical screening panel, limit on awards, a patient reimbursement fund, medical evaluation commission, and modification of the contingency fee.

About 40% of physicians are insured under a society-sponsored program with St. Paul, which recently switched to claims-made. Rates increased 25% July 1, when the switch was made, and probably will double Jan. 1. Medical Protective, the state's other major insurer, is writing no new policies, and other companies are moving out of the

Nevada

During 1975, the legislature approved formation of a JUA, extended the Good Samaritan Act to hospitals, established mandatory screening panels, increased authority of the licensing board, and made several changes in tort law. No session will be held this year, but an interim study commission is at work on additional reforms.

The JUA has gone into effect and covers some 150 physicians. Other carriers include Argonaut, which is being selective about new business and may pull out altogether in May, and Imperial, which will take no new business. Argonaut did have an eight-year contract with the medical society. It has pulled out of this, though continues to write some new coverage. The society did not have figures on rates, which vary considerably from individual to individual. Rates for most did go up considerably.

New Hampshire

Confronted with a doubling of liability premiums, the New Hampshire Medical Society obtained the creation of a JUA and establishment of a state commission to study all facets of the medical injury reparations system. The commission's recommendations are due on or before Jan. 1, 1977.

The NHMS reports the state's physicians "generally have no trouble" obtaining adequate coverage, primarily with Hartford, which has 80% of the business. Increase in claims was described as substantial.

New Jersey

No legislation made it through the New Jersey General Assembly during 1975. A number of bills are expected to be submitted in 1976. Among the state medical society's legislative suggestions are measures dealing with the statute of limitations, res ipsa loquitur, informed consent, collateral source requirement, limiting amount of liability required, and mandatory panels for screening. New Jersey physicians are presently able to get coverage. The society-sponsored carrier, Chubb and Sons, covers almost all state society members.

Premiums are rising. For 1976, they will increase on an average of 50%. Class I physicians will note a rise of nearly 75%, while Class V physicians will see their premiums increase by 30%. According to a spokesman for the medical society, the rate of claims filed is up markedly. Figures for calendar 1974 showed a 60% increase.

New Mexico

No legislation was passed in 1975, but a study commission was formed to recommend reforms. With the announced pull-out of the only carrier, Travelers, on March 1, measures will have to be approved quickly to guarantee coverage. Plans for both a JUA and a physicians' mutual have been readied for immediate consideration. Other measures to be introduced include a state-operated patient's compensation fund, a limit on liability and on awards, mandatory screening panels, tougher laws to discipline physicians, and several tort reforms.

Rates increased 74% last May, putting premiums at between $913 and $5,781 for $1 million coverage.

New York

Last year, the legislature approved establishment of a JUA, and a physicians' mutual, passed reforms on physician discipline matters, allowed recommendations of mediation panels to be admissible in court, and granted other tort reforms. This year, the medical society plans to introduce its Patients' Indemnification System, which will take suits out of the court room into an arbitration process. Also planned to be introduced are measures limiting awards and contingency fees, and calling for numerous tort reforms. Both the JUA and physicians' mutual have been put into effect.

Some 15,500 physicians are covered by the mutual, 3,500 by the JUA. Rates increased about 20% during the year. High-risk physicians in New York City pay about $17,000 as of July 1. The society reported 2,000 claims in 1974 and 1,324 for the first part of 1975.

North Carolina

State legislators approved a reinsurance exchange that has been challenged in the courts by involved insurance carriers. All companies except the society's own mutual have received injunctions exempting them from participating. Other laws passed in 1975 strengthen the board of medical examiners and establish a study commission. The medical society is recommending the commission consider establishment of a patients' compensation fund, a limit on liability, a mechanism for easier filing of counter-claims and several tort reforms.

Coverage in the state is available only through the physicians' mutual or through the St. Paul claims-made program. A premium increase of 570% was approved in October. Physicians in the mutual pay between $967 and $7,872 for $100,000/$300,000 coverage. Claims have increased about 67%.

North Dakota

Most physicians can obtain solid coverage and with conversion to a claims-made policy, some North Dakota physicians actually experienced a slight decrease in their premiums for the first year, the state medical society reports. However, the occurrence policies doubled and umbrella coverage jumped 100-200%. Without required reporting of claims, the society notes, it is difficult to determine if claims increased.

During 1975, the NDMA was successful in having the statute of limitations amended to two years after discovery, with a maximum of six years; protecting medical society and hospital review records from discovery and making them inadmissible as evidence; and gaining authority to establish a mutual liability insurance company. Next year, the society will sponsor a comprehensive bill, including tort reform, screening panels, and arbitration.

Ohio

Through the efforts of Ohio physicians an extensive package of reform measures passed the legislature in 1975. These included a limit on awards for pain and suffering, limit on contingency fees, establishment of JUA, provisions for binding arbitration, strengthening of the medical board, and numerous tort reforms. The society hopes to modify the JUA plan this year and to introduce other reform measures. The JUA has gone into effect. The society also is investigating formation of a mutual company.

Six carriers currently write coverage, including Medical Protective, Buckeye Union, Shelby Mutual, St. Paul, Travelers, and Hartford. Aetna began pulling out of the state this month. Rates increased as much as 700% in the state. Physicians pay between $900 and $7,500 for basic coverage.

Oklahoma

Oklahoma physicians remain in a relatively good position, with comparatively low rates under two medical-society-sponsored plans—though basic coverage premiums ($100,000-$300,000) increased 35% and excess coverage increased 200% this year. Basic coverage under the sponsored Insurance Company of North America plan ranges from $273 to $1,594, and excess coverage under CNA to $1 million also ranges from $273 to $1,534.

Though there are no other active carriers in the state, physicians do not as yet have trouble getting coverage. There have been no new legislative reforms this year, but the Oklahoma State Medical Assn. plans to introduce a package of several bills, including a measure to provide for written warranty and a redefinition of the statute of limitations.

Oregon

The medical society has asked the state court to rule on the constitutionality of a new law that limits physicians' liability and sets up a state excess fund. Also passed by the legislators last year were measures to limit contingency fees, permit creation of a physicians' mutual company, strengthen the medical practice act, and reform various tort laws. The legislature will not meet this year, but a state task force will study additional reforms.

The society has a group plan with CNA that charges between $1,116 and $7,240 for $100,000/$300,000 coverage. CNA has just requested an increase for the coming year of about 20%, which will put rates for the basic coverage at between $1,340 and $8,692. Protection is available up to $5 million at a cost of between $2,540 and $15,796, under the newly requested rates.

Pennsylvania

The Pennsylvania Medical Society last year reluctantly backed a new liability law in that state, creating a joint underwriting association only for those physicians who can't get coverage elsewhere, plus mandatory pretrial screening panels —but the society hopes to win some more effective changes in this year's legislature. The physicians hope to bolster the new law by reducing the statute of limitations, improving the composition of screening panels, and banning pain and suffering awards.

Private insurance is available from Medical Protective, Argonaut, and Aetna, and from the joint underwriting association for those refused by the private companies. Meanwhile, the medical society is studying formation of a captive insurance company. Private coverage rates jumped substantially this year—from 67% to as much as 476% higher than last year—from a Class I low of $538 (Medical Protective) to a Class V high of $15,277 (Argonaut).

Rhode Island

Rhode Island adopted a joint underwriting association plan this year, so that physicians have no trouble obtaining coverage—though rates increased 200% this year. The legislature has not passed any liability reform laws, though the Rhode Island Medical Society is planning to develop and introduce a comprehensive malpractice reform package next year.

Officials estimate malpractice claims increased 50-60% this year over last.

South Carolina

The legislature created a joint underwriting association that went into effect July 1, and a study commission to propose legislation to the governor by March.

The state medical society is working for a package bill similar to the AMA model, including: reduction of statute of limitations, limit on damages, binding arbitration, limit on contingency fees, and elimination of the ad damnum clause. The society also plans to introduce a bill that would set up a new medical discipline system.

Current premium for Class I for basic $100,000/$300,000 coverage is $250 and for Class V, $1,400, a 100% increase over 1975. No claims have been filed under the JUA; earlier figures are not available.

South Dakota

In South Dakota, physicians backed measures granting peer review immunity and a reduction in the statute of limitations this year; and the state medical association will probably introduce a package of 10 bills next year, including voluntary binding arbitration and a joint underwriting association. The legislative push was prompted by a change from occurrence to claims-made coverage in the state, plus a big increase in premiums.

Premiums range from $550 to $12,356 (last year, the range was $164 to $8,650). Though St. Paul, Aetna, USF&G, Hartford, Western Casualty & Surety, and Western Fire & Casualty all write policies, state society officials report that new physicians in solo practice have difficulty finding insurance—though, so far, all have been able to find acceptable coverage. The society hopes to get a joint underwriting association approved by next year's legislature; a similar measure failed this year.

Tennessee

The Tennessee legislature passed a comprehensive package of liability reform bills last year, creating a joint underwriting association, malpractice review boards, plus major changes in tort law, including reduction of statute of limitations, limits on contingency fees, and allowance of counterclaims by physicians. Further improvements in the legislation are being planned by the Tennessee Medical Assn.

However, high premiums for coverage under the joint underwriting association remain a serious problem—rates for the highest category of coverage rose from ISO's $897 in September, 1974, to $12,509 under the JUA this fall. Class I coverage rose from $176 in September, 1974, to $1,532 as of the end of this year. The JUA was implemented when Shelby Mutual, the state's biggest insurer, announced it would withdraw coverage next April, and other firms started phasing out as soon as the JUA went into operation. The medical association approved plans to start a physician-owned company, but the firm must be capitalized for $4 million before it will be approved by the state insurance commissioner.

Texas

In 1975, bills were passed allowing formation of a JUA, establishing a study commission, regulating insurance rate increases, and lowering the statute of limitations. The medical society has put together a 22-point plan for the commission recommending such reforms as a limit on awards and on contingency fees, establishment of arbitration boards, strengthening of the board of examiners, and other tort reforms.

Excess coverage in the state is not written through the JUA and is difficult to obtain. Medical Protective writes 60% of the policies. Other carriers include Hartford, Aetna, and St. Paul. Travelers pulled out of a group plan in Harris County on Nov. 1. Increases in rates of 600% to 800% were the norm last year. Many increases were even higher.

Utah

The Utah State Legislature will meet in 1976 for a 20-day session during which a malpractice bill, sponsored by several groups including the Utah Medical Society and the Utah Bar Assn., will be introduced. The bill will likely include a $250,000 cap on awards, reform of the statute of limitations, a requirement of a 90-day notice of intent to serve, elimination of the ad damnum clause, and a requirement of disclosure of collateral sources. A companion bill is expected to be introduced that will call for strengthening of the state's Medical Practice Act. Two measures will involve strengthening licensure laws and, increasing the size of the physician's examining committee.

Coverage is available to physicians in Utah. Aetna, the primary carrier, is in the last year of a five-year contract, but has indicated it will extend coverage for at least another year. Premiums increased in 1975. For 1976, they will rise an additional 70%. Class I physicians, for $100/$300,000 coverage, have seen premiums rise from $769 to $1,260. Neurosurgeons, for $250/$500,000 coverage, have seen premiums go from $6,186 to $10,603.

Vermont

Faced with a proposed 163% increase in premiums for next year, the Vermont State Medical Society is backing a package of four bills and a resolution to be submitted in the next session of the state legislature—the first sortie into liability reform.

Physicians as yet have no difficulty obtaining coverage, either through the medical society's sponsored program with Aetna, or with Hartford or St. Paul. Society officials estimate claims against physicians were up 50% last year over 1974, and if proposed premium increases are approved, physicians will pay from $1,400 (Class I) to $11,950 (Class V) for coverage.

Virginia

The state medical society plans to introduce a comprehensive package in the 1976 session of the legislature. A physician-owned reciprocal exchange is being organized, with no connection to the society.

St. Paul insures 90% of physicians in a society-sponsored plan. Basic premiums remained the same this year, though $1-million excess coverage jumped 100%.

Claims for the first six months of 1975 were 50% higher than for the same period in 1974.

Washington

Members of the Washington State Medical Assn. who do not have an adverse malpractice litigation record have no trouble obtaining coverage—90% of the business through Aetna—and the medical society does not plan to seek either a JUA or its own company.

During the past year, WSMA obtained passage of a standard of care bill, an expanded Medical Disciplinary Act, an amendment to the Medical Practice Act to provide for continuing education, and passage of a Good Samaritan Act. In 1976, the society will pursue a broad legislative program, including limitations on awards and contingency fees, screening panels, and various reforms in tort law.

The society estimates claims increased about 12% and premiums 70%.

West Virginia

The medical society is supporting legislation for 1976 that would establish a joint underwriting association and effect a number of tort reforms.

Aetna Life and Casualty is the only company writing new policies, and only under the society-sponsored program. Aetna received a 48% premium increase for basic coverage in 1975 and is seeking a similar increase for 1976.

Wisconsin

After a full year of legislative battles, Wisconsin physicians won several reforms of liability laws, including limits on liability, joint underwriting association, patients' compensation fund, and pretrial screening panels.

Physicians no longer have trouble getting insurance, though the State Medical Society of Wisconsin is investigating a physician-run liability program. Medical Protective, St. Paul, and Wisconsin Health Care Liability Insurance Plan all continue to write new policies, though St. Paul is limited to claims-made and Medical Protective is largely restricting new coverage to low-risk specialties and rural areas. Medical Protective's rates increased 10%-30% this year, to a high of $3,411 in Class V, while ISO's rates increased about 70%, to a high of $2,274. Figures on number of malpractice claims filed this year have not been compiled.

Wyoming

Obtaining adequate coverage is not a major problem, according to state medical society executive director Robert Smith. St. Paul withdrew from the market, but a society-sponsored plan with Aetna, which covers 80% of the state's physicians, took all those who lost coverage. The remaining 20% are covered by Hartford.

The society is proposing legislation for 1976 that would include: a two-year statute of limitations; disabled physician act; state reporting law; expanded immunity for persons involved in review; informed consent legislation; joint underwriting association; and a patient compensation act.

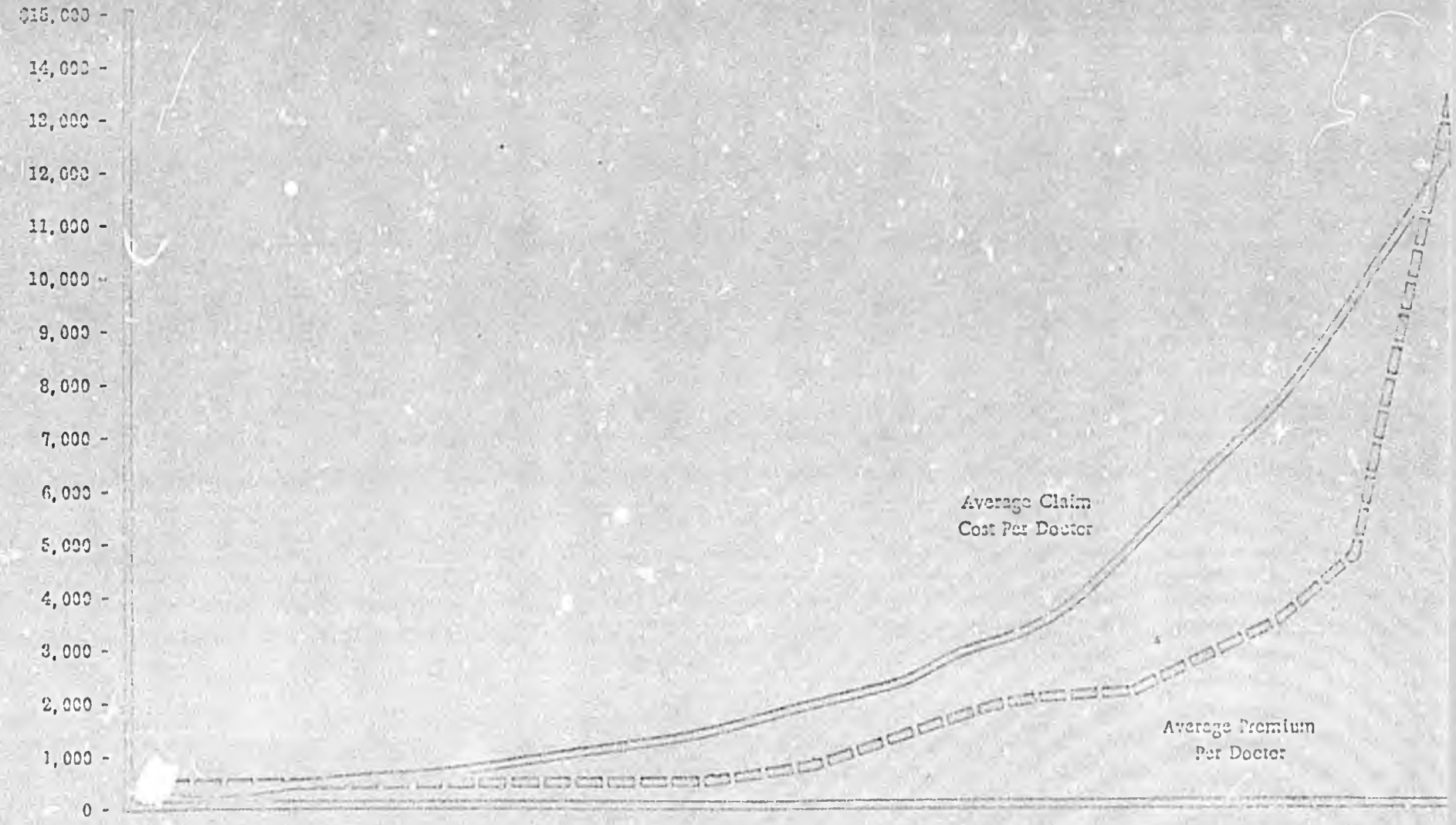
Information is not yet available on the size of premium increases for 1976. Except for one $200,000 loss, the highest in the state's history, awards for 1975 are lower, so far, than last.

THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

Classification	Proportion Of Doctors	Premium Relationship: Indicated 1970 ISO Rate	Indicated 1970 Premium
Physicians - no surgery	62%	0.100	$ 2,000
Physicians - minor surgery or assisting in major surgery on own patients (6% or less)	15	100	11,000
Ophthalmologists	2	900	10,000
Proctologists	*	850	10,000
Cardiologists - including catheterization, but not including cardiac surgery	2	290	10,000
Anesthesiologists	4	300	10,000
Urologists	1	3[illegible]	20,000
Otolaryngologists - plastic surgery	1	850	85,000
Otolaryngologists - no plastic surgery	1	440	20,000
Cardiac surgeons	*	400	30,000
Obstetricians - gynecologists	5	430	31,000
Plastic surgeons	*	500	33,000
Surgeons - general - specialties in general surgery	6	550	36,000
Orthopedists	3	700	43,000
Thoracic surgeons	1	870	52,000
Vascular surgeons	*	940	60,000
Neurosurgeons	1	970	72,000
Total	100%	220 (average)	$ 14,000

* Less than 1%

Source: Insurance Services Office -- Physicians and surgeons countrywide excluding Texas, policy years ending 1969 - 1970


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Cost Per Doctor
Average Premium
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THE PRECEDING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

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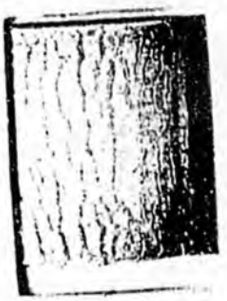
PMS TERRY GARDINER CARE HOUSE JUDICIARY COMMITTEE 1976 JAN 27 AM 10 57

JUN" 0919

AS PRESIDENT OF THE ALASKA CHIROPRACTIC SOCIETY
I HAVE BEEN DIRECTED BY ITS MEMBERS TO REQUEST
YOUR ASSISTANCE IN EXCLUDING (TOTALLY)DOCTORS
OF CHIROPRACTIC FROM SB522 MALPRACTICE CLAIMS ARE NOT
A PROBLEM WITH OUR PROFESSION AND OUR MEMBERS ARE
ADEQUATELY INSURED THROUGH OUR NATIONAL CHIROPRACTIC
AS ORGANIZATION FOR OUR PATIENTS PROTECTION

CECIL S MCLEOD DR

#



Members file on Malpractice

ALASKA DENTAL SOCIETY

OFFICE OF THE PRESIDENT

January 10, 1976

Mr. Langhorne Motley
Commissioner
Pouch D.
Juneau, Alaska 99811

Dear Commissioner Motley:

The Alaska Dental Society wishes to reaffirm it's position in relation to the Malpractice Insurance Commission's proposed legislation.

We object to mandatory inclusion in a joint under-writing association and adhere closely to the points and reasoning brought out in a report to the legislature made by Dr. H.S. Denenberg.

Sincerely;

Robert R. H. Sutherlin DDS

R.H. Sutherlin
President
Alaska Dental Society

cc: All legislators
All Health Care Associations
Governor
Director of Insurance

TERRY GARDINER
STATE REPRESENTATIVE
POUCH V
JUNEAU
99811

BOX 1092
KETCHIKAN
99901

Alaska State Legislature

January 30, 1976

Bill Henrickson
Ketchikan Medical Clinic
3612 Tongass Ave.
Ketchikan, Alaska 99901

Dear Dr. Henrickson,

Thank you for your letter in regard to SB 113. SB 113 passed through House Judiciary Committee last year and evidently got stuck in the Rules Committee. As I understand it this issue is not taken care of in the Governor's recommended legislation on medical malpractice. Before passing out the medical malpractice legislation, I will make sure that this issue is taken care of. The issue is not resolved in the Governor's proposed legislation. We will either include it or make sure that SB 113 is passed this session.

The House Judiciary Committee and the Senate Commerce Committee have both been putting in a lot of hours on the malpractice issue. I am confident that we will eventually pass legislation that will be more far-reaching than the malpractice commission's recommendations.

Sincerely,

Terry Gardiner

Ketchikan Medical Clinic

3612 TONGASS
KETCHIKAN, ALASKA 99901

J. W. Mortensen, M. D.
H. J. Henrickson, M. D.
D. E. Johnson, M. D.

Phone 225-5144
Phone 225-5145

January 14, 1976

Representative Terry Gardiner
Alaska House of Representatives
Juneau,
Alaska 99801

Dear Terry:

Senate Bill 113 which passed, seems to be stuck in committee in the house. If the number is correct, this is the bill that protects the physician from suits while carrying out normal functions on the various hospital committees and boards upon which he must serve.

All of us feel very strongly that we must police our own ranks but in order to do so, must have some freedom from fear of being sued for such actions as we must take.

Any help you can give us in getting this bill out of committee would be appreciated.

Sincerely,

Bill

H. J. Henrickson, M.D.

Settlement Delays Drive Up Costs

The malpractice problem is further aggravated by the long time required to resolve claims. According to lawyer James E. Ludlam, of Los Angeles, a specialist in hospital professional liability problems, a malpractice case generally takes 5–6 years to settle.

"In such cases," he says, "defense costs alone can total $30,000, and both sides might spend $100,000." (In addition, it is estimated that every day of trial costs the public about $1,000 just to maintain that part of the court system.)

Such delays work hardships for all parties concerned and drive up costs of eventual settlement. Ludlam calls our present system for resolving medical malpractice cases "extraordinarily expensive, inefficient, and most erratic." (Source: *Reader's Digest*, 4/75.)

The Lawyer's Contingency Fee

The U.S. is the only major nation that allows the contingency fee system, in which a lawyer obtains a fee only if he wins. In return for this risk, he receives on average ⅓ to ½ of the court award.

Lawyers say that without this system, some patients with valid suits could not afford to press them. On the other hand, many claims are rejected by lawyers because the potential return is too small.

In New Jersey, a sliding-scale contingency fee has been established: 50% of the first $1,000 in the settlement; 40% of the next $2,000; 33⅓% of the next $7,000; 20% of the next $50,000; no more than 10% of any award exceeding $100,000. Some insurance experts believe the New Jersey Rule might reduce total malpractice losses as much as 20%.

How Settlements Are Increasing in Some Troubled States

State	Year	Total Settlements	Average Paid
Cal.	1969	—	$4,500 (NoCal)
			5,600 (SoCal)
	1973-4	—	7,000 (NoCal)
			8,000 (SoCal)
	1975		12,000 (estimated statewide)
	1980		25,000 (estimated statewide)
	1985		62,000 (estimated statewide)
Fla.	1963	—	1,182
	1975		20,000 (estimated)
Ill.	1974		40,099
	1975		93,465
N.Y.	1963	$ 1,405,000	4,878
	1969	4,865,490	10,788
	1973	17,452,000	22,894

The above chart shows how average settlements are increasing in some states where the malpractice problem is particularly acute. The sharply geometric upward spiral in these settlements presents a frightening prospect to insurance companies trying to set realistic premiums to cover future claims and to physicians already heavily assessed for such coverage.

California Is Hardest Hit with $1 Million-Plus Awards

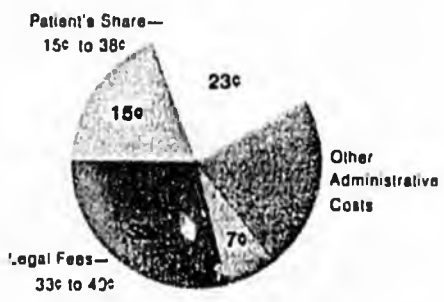
16 in California history prior to 1/74
3 prior to 1971
13 since 1971
11 in 1973-74

1 per month on average, 1975

The increasing number of $1 million-plus claims and the willingness of California juries to make 7-figure awards is one reason why claims paid in that state jumped from $15 million in 1971 to $31 million in 1974. Currently, there is even a claim pending for $1 billion!

Source: California Medical Association.

Meanwhile, the Patient's Share Gets Smaller



Patient's Share of Malpractice Premium Dollar



Patient's Share of Workmen's Compensation Premium Dollar

A 1974 study by the Physicians Crisis Committee in Michigan found that less than 25¢ of the premium dollar goes to patients—the rest goes for legal fees and other expenses. A similar study at Chicago's Presbyterian-St. Luke's Hospital recently found an even smaller portion going to injured parties—only 15¢ of every dollar. The 38¢ estimate that goes to the plaintiff is one advanced in the Library of Congress's "Overview of Medical Malpractice." In an interesting contrast, an injured party's share of an award under Workmen's Compensation varies from 70¢ to 75¢.

Section II begins on page 18

PROFESSIONAL BUILDING
529-6TH AVENUE

PHONE 451-3393
451-4206

Henry G. Storrs. M.D.
SURGEON
FAIRBANKS, ALASKA

February 16, 1976

Charles Parr
Alaska Legislature
Pouch V
Juneau, Alaska 99801

Dear Mr. Parr:

Thank you for spending your Saturday afternoon discussing the pending malpractice legislation with the doctors of Fairbanks. It is interesting to note that of the almost thirty doctors there, all but two were specialists!

Two points that should probably be considered, perhaps when the bill goes to joint conference with the senate version are; first, limiting the plaintiff's attorney fees to "usual, customary, fair and average." The attorney fees in this area are standardized at between $50 and $60 an hour. The medical profession has been well limited to "fair, reasonable, just and average," etc. fees. There is no reason why the attorneys should not likewise be regulated, at least when dealing in this field of their endeavor. Of course, if they wish to forego collection of a fee if their case is unsuccessful, that would be between them and their client. But such a reduction in fees would tend to reduce the enthusiasm with which they persue useless or "nuisance" cases.

The second point is the limitation of the entire award, taking into consideration other compensation which the citizen may be receiving. The monthly payments are certainly a step in this direction. It should be pointed out that workmen's compensation has a definite fee award limit for damages sustained. It would appropriately apply to the practice of medicine. Sometimes an injured worker is collecting for an injury under workmen's compensation, but then with the aid of some attorney decides he may collect for the disability from a doctor who obtained a less than perfect result from his attempts to correct the injury. The awards in such a case do not take into consideration either the fact that he has already been awarded damages for his injury, nor do they as yet limit his medical award to even the same range of damages.

One final point I hope will be included in the bill is the retroactive date to January 1975 to include all uninsured physicians during any period of that time for both claims made or occurred and whether or not they have been filed.

Thanks again for your interest in this matter.

Sincerely yours,

Henry G. Storrs, M. D.

HGS/ch

DISTRIBUTION OF LOSSES
MEDICAL MALPRACTICE
ONE YEAR EXPOSURE

	1976	1977	1978	1979	1980	1981	1982	1983	19 –
INCIDENTS	1000000								
REPORTED		450000	250000	150000	50000	25000	12500	12500	50000
PAID		100000	200000	300000	250000	25000	12500	12500	100000

DISTRIBUTION OF PREMIUM
MEDICAL MALPRACTICE
CAR YEAR EXPOSURE

	1976	1977	1978	1979	1980	1981	1982	1983	19—	TOTAL
OCCURRANCE										
CLMS REPORTED	0									
CLMS PAID	0									
IBNR	1000000 —									
PURE PREMIUM	1000000 —									1000000 —
CLAIMS MADE										
CLMS REPORTED		450000 —	250000	150000	50000 —	25000 —	12500 —	12500 —	50000 —	
CLMS PAID										
IBNR										
PURE PREMIUM		450000	250000	150000	50000	25000	12500	12500	50000 —	1000000
[redacted] **CLAIMS PAID**										
CLMS PAID		100000	200000	300000	250000	25000	12500 —	12500 —	100000 —	
PURE PREMIUM		100000	200000	300000	250000	25000	12500	12500	100000 —	1000000 —

DISTRIBUTION OF PREMIUM
MEDICAL MALPRACTICE
ONE YEAR EXPOSURE

	1976	1977	1978	1979	1980	1981	1982	1983	19—	TOTAL
COMMISSION										
CLMS RPTD										
CLMS PAID					150000	25000	12500	12500	100000	
IBNR	700000									
PURE PREMIUM	700000				150000	25000	12500	12500	100000	1000000

EIGHT YEARS OF EXPOSURE
MEDICAL MALPRACTICE

	1976	1977	1978	1979	1980	1981	1982	1983	19--	TOTAL
INCIDENTS	1000000	1000000 -	1000000	1000000	1000000	1000000	1000000	1000000		8000000
REPORTED	ø	450000 -	700000	850000	900000	425000	937500	950000	2287500	8000000
PAID	ø	100000 -	300000	600000	860000	875000	887500	900000	3487500 -	8000000

DISTRIBUTION OF PREMIUM
MEDICAL MAL PRACTICE
EIGHT YEARS OF EXPOSURE

	1976	1977	1978	1979	1980	1981	1982	1983	19 –	TOTAL
OCCURRANCE	1000000	1000000	1000000	1000000	1000000	1000000	1000000	1000000	0	8000000
CLMS MADE	0	450000	700000	850000	960000	925000	937500	950000	2287500	8000000
CLMS PAID	0	100000	300000	600000	850000	875000	887500	900000	3487500	8000000
COMMISSION										
OCCURRANCE	700000	700000	700000	700000	700000	700000	700000	700000	0	5600000
PAID	0	0	0	150000	175000	182500	200000	300000	1392500	2400000
PURE PREMIUM	700000	700000	700000	850000	875000	882500	900000	1000000	1392500	

DISTRICUTION OF PREMIUM
MEDICAL MALPRACTICE
EIGHT YEAR OF EXPOSURE
25% REDUNDANCY REDUCED BY DEVELOPMENT

	1976	1977	1978	1979	1980	1981	1982	1983	19—		TOTAL	CAVAE
OCCURRENCE POLICY												
LOSS DEVELOPMENT	~~1,250,000~~	450000	700000	850000	900000	925000	937500	950000	50000			
IBNR	1300000	<112500>	<62500>	<37500>	<12500>	<4250>	<3125>	<3125>				
PURE PREMIUM.	1250000	1132500	1085000	1037500	1025000	1018750	1015625	1012500			$ 8571875	
COMMISSION												
LOSS DEVELOPMENT	∅	450000	700000	700000								
IBNR CHANGE	875000	<112500>	<62500>	∅								
~~PURE PREMIUM~~												
(CF) CLAIMS PAID	∅	∅		150000	175000	182500	200000	300000	1392500			
(IC) PURE PREMIUM	875000	762500	700000	700000	700000	700000	700000	700000				
PUTRO ADJUSTMENT	∅	∅	∅	∅	<43750>	<59375>	<59375>	<59375>	<15625>			
NET PREMIUM	875000	762500	700000	850000	831250	823125	840625	940625	1376875		$ 6623125	13768

$ 8,000,000

RECOMMENDATION OF GOVERNOR'S COMMISSION ON MALPRACTICE

RECOMMENDATION #1: The liability of the health care provider should terminate three years after occurrence (two years statute of limitations and one year limit on discovery). Any reported case after the third year ought to become the responsibility of a special fund and not the liability of the health care provider.

RECOMMENDATION #2: Any award to which the injured patient is entitled should be reduced by all available collateral sources such as private, group or governmental medical or disability benefits whether contributory or noncontributory, except life insurance, by including the introduction into evidence of the items of damage compensated by collateral sources, except federal programs which by law must seek subrogation.

RECOMMENDATION #3: Medical professionals should be immune from liability to a person who is not his patient for administering emergency medical care where the giving of immediate aid appears to be the only alternative to death or serious bodily injury or harm.

RECOMMENDATION #4: The law should provide that no promise to achieve a certain medical result is valid unless that promise is in writing signed by the health care provider.

RECOMMENDATION #5: The definition of medical negligence be improved by adopting a national standard of acceptable medical care in lieu of a local community standard, limiting the standard to that at the time of the act, and imposing the standard appropriate under all circumstances under which the health care provider was acting.

RECOMMENDATION #6: Cases brought more than three years after the date of the incident alleged to cause the loss complained of must be proven by evidence that is clear and convincing.

RECOMMENDATION #7: There be enacted provision for appointment of ad hoc medical expert panels composed of at least one physician and two health care providers of the same discipline as the health care provider charged, impanelled after filing of an action and prior to any pretrial proceedings to initiate an investigation of available evidence and report to the parties its findings as to medical facts.

RECOMMENDATION #8: The findings of the expert medical panel be admissible as evidence and the panelists subject to cross-examination in any subsequent trial.

RECOMMENDATION #9: There be established a medical adjudication board consisting of nine citizens of the State who are neither health care providers nor legal professionals, nor insurers, and three physicians appointed by the Governor, and one Superior Court judge assigned by the court. This board would be the exclusive tribunal for medical negligence cases.

RECOMMENDATION #10: The legislature enact a joint resolution for the amendment of Article I, Section 16 of the Alaska State Constitution, permitting the legislature to consider an alternative system of adjudicating medical negligence claims which may be a substitution for trial by jury.

RECOMMENDATION #11: Provisions be made to authorize and administer the awards of future income and continuing medical care to be paid periodically rather than in a lump sum.

RECOMMENDATION #12: Jury and board awards shall be rendered by category of loss.

RECOMMENDATION #13: Create a Health Care Providers Indemnity Corporation, a public corporation, which would be regulated by the Director of Insurance as a domestic property and casualty insurer and which would be a mandatory and exclusive source of minimum limits of madical malpractice insurance for all health care providers for the losses reported within the first three years after occurrence.

RECOMMENDATION #14: The corporation may contract with servicing carriers for administrative and claims services and seek contracts of indemnity from admitted carriers retaining for itself no insurable risk.

RECOMMENDATIONS #15: The rates for coverages provided by the corporation should be developed based on Alaska's experience and retrospectively adjusted over a four year period such that each category of health care providers would fully pay for all losses and expenses incurred in the programs yielding an appropriate profit to the indemnity carrier.

RECOMMENDATION #16: The corporation provide coverage retroactively to January 1, 1975 with appropriate additional premiums for those health care providers which had no insurance during that period.

RECOMMENDATION #17: A joint underwriting association should be authorized to be implemented upon a finding by the Director of Insurance that indemnity at a reasonable rate is not available from a private carrier.

RECOMMENDATION #18: The joint underwriting association should be composed of all property, casualty and disability insurers and all health care service contractors.

RECOMMENDATION #19: Create a late claims fund which shall be funded by assessments against all health care providers in amounts determined by the Director of Insurance after public hearing as necessary to actuarially carry all fund liabilities and guaranteed by the State to the extent necessary to cover actuarial deficiencies. There should also be provision for the legislature to reduce the assessment of health care providers upon a finding that the assessment is unaffordable.

RECOMMENDATION #20: Legislation should be enacted which will require the maintenance of separate, specific and detailed statistical information on malpractice claims. Authority should be exercised by the Director of Insurance to more deliberately regulate policy forms and rates for this line.

RECOMMENDATION #21: The proposals of this Commission should inure to the benefit of, and be binding upon all licensed in the State as hospitals, as defined in AS 18.20.130 chiropractors, dental hygenists, dentists, physicians, osteopaths, chiropodists, nurses, opticians, pharmacists, physical therapists, psychologists and psychological assistants.

RECOMMENDATION #22: There should be a legislatively prescribed procedure for informing the patient of the consequences of a procedure and obtaining the consent to perform it and also setting forth the conditions pursuant to which consent is implied or not required.

RECOMMENDATION #23: The appropriate licensing boards should be authorized to render disciplinary sanctions against health care providers other than license suspension. The boards should be able to reprimand, censure, place on probation, restrict practice by time, specialty, procedure or facility or to require continuing education or retraining.

RECOMMENDATION #24: The appropriate licensing board should have authority to require more relevant and more frequent reports on healthcare practices by and from its licensees. Persons reporting should have immunity from defamation actions based on reports made to licensing boards to officially constituted service committees of hospitals and professional organizations.

RECOMMENDATION #25: The legislature appropriate such additional funds as are needed to properly staff the health care licensing boards with investigative and administrative personnel.

RECOMMENDATION #26: Provision should be made for more effective loss control by all health care providers but with specific attention to identified problem areas.



Dept. Administration. — 10th (Lobby Card.)

Dept Commerce — 9th.

Booklet of Legislaters

Committees

Senate - Commerce
Judiciary

House - Judiciary



January 25, 1976

MEDICAL and DENTAL MALPRACTICE in ALASKA
1957-1974
Known Claims or Suits
(after Plewett, Anchorage Daily News, July 31 & August 4, 1975)
data re-arranged

Year	Number of Claims	Annual Sum of Reported Settlements
1957	3	$ 395,000
1958	2	100,000
1959	2	130,000
1960	3	100,000
1961	2	30,000
1962	9	46,500
1963	4	60,000
1964	3	180,050
1965	3	63,545
1966	4	87,000
1967	6	335,000
1968	0	-0-
1969	4	-0-
1970	7	187,750
1971	7	565,500
1972	3	503,500
1973	1	7,500
1974	3	119,000
	66 (av 3.7/yr)	2,871,345* (av 160,000/yr)

*Includes $ 230,000 awarded against dentists

Awards or Settlements by Type of Practice

Surgery	15
General Pract	9
OB-GYN	4
Neurosurgery	3
Orthopedics	3
Dental	2
Internal Med	2
Radiology	1
	39

Claims or Suits Pending August 4, 1975

OB-GYN	7
Surgery	5
General Pract	4
Hospitals	3
Anesthesiology	1
Orthopedics	1
Pathology	1
Radiology	1
	23

Title Mal Practice

Alaska State Legislature

LEGISLATIVE AFFAIRS AGENCY

POUCH Y, STATE CAPITOL
JUNEAU, ALASKA 99811
(907) 465-3800

MEMORANDUM

February 7, 1976

Anchorage Medical Clinic
185,000 – 30 doctors 6,000

SUBJECT: Medical Malpractice Statistics (W.O. #1911)

TO: The Honorable Robert Bradley
The Honorable Terry Gardiner

FROM: Louise Crane
Research Analyst L.C.

The following information was compiled at your request:

1. TOTAL MEDICAID EXPENDITURES BY THE STATE:

Actual Expenditures	FY 74		$ 6,869,286
Actual Expenditures	FY 75		11,366,100
Authorization	FY 76		14,445,900
Expenditures to date		$ 4,312,400	
Balance & Restricted Funds		$10,133,500	
Budget Request	FY 77		$17,908,500

2. NUMBER OF PHYSICIANS ENROLLED IN MEDICAID PROGRAM.

FY 74	359
FY 75)	357
FY 76)	

3. TOTAL MEDICARE EXPENDITURES BY THE FEDERAL GOVERNMENT

FY 71	$434,000
FY 72	523,000
FY 73	
FY 74	987,000

(No physician enrollment is necessary in the Medicare Program.)

4. PHYSICIAN EARNINGS STATISTICS

The state (for HEW) collects physician earnings statistics from Medicaid information. No individual physicians earned more than $100,000 during FY 74 (the latest year the information is available). Three group practices received more than $100,000 in Medicaid payments during FY 74. These are as follows:

Alaska Clinic, Anchorage	$177,762
Fairbanks Medical & Surgical, Fairbanks	118,949
Tanana Med. & Surg. Clinic, Fairbanks	108,289

The Medicare Program requires an investigation of physicians receiving over $65,000 in Medicare payments in one year. The Social Security Office is not aware of any investigations.

You also requested information on the income distribution of Alaska physicians; this data is available but will require compiling the social security numbers from the Department of Commerce files, requesting a special computer run by the Department of Revenue to accumulate the information, and adjusting the information.

In the time alloted, the Research Division has been unable to allocate the more than 80 man-hours estimated as necessary to compile this information. An appropriately directed legislative request might elicit this information directly from the Department.

5. TOTAL MEDICAL MALPRACTICE PREMIUMS BY ALASKAN PHYSICIANS

The Division of Insurance, Department of Commerce & Economic Development is, at the request of the Legislative Affairs Agency, conducting an individual policy survey by polling each broker who markets medical malpractice insurance in Alaska.

The information is being compiled, but there are several crucial elements of information unavailable to date. A supplementary report will be issued as soon as the information is available and edited.

An important tie-in to the factors related to the malpractice premium distribution is that many "high exposure" physicians (class 4, 5 and 6 - i.e., speciality surgeons, etc.) are not purchasing insurance and this factor will skew the validity of the averages.

6. MEDICAL MALPRACTICE PREMIUM DOLLAR BREAKDOWN

The following table illustrates the expense categories that are taken into consideration by insurance companies in developing medical malpractice premium rates. The two columns of figures indicate the percentages of the premium allotted for each cost category according to two different sources. The Insurance Service Office (ISO) is an independent rating organization used by member insurance companies. The "range reported by insurance companies surveyed" refers to a sample survey of medical malpractice insurers by the contractor who prepared an economic analysis of the medical malpractice insurance market for the Secretary's (HEW) Commission of Medical Malpractice, 1973.

ECONOMIC ANALYSIS OF THE MEDICAL MALPRACTICE INSURANCE MARKET ON A NATIONAL LEVEL - 1972

Expense Category	Factors	
	Average Reported by ISO	"Range Reported by Insurance Companies Surveyed"
Acquisition/production	25	5 to 20
Administration/general overhead	12	5 to 12
Miscellaneous	3	3 to 5
Underwriting profit	5	5
Loss adjustment & loss	55	55 to 86

The Department of Commerce & Economic Development has indicated that the medical malpractice insurance premiums in Alaska show approximately the same distribution as the national level listed above.

7. THE NUMBER OF PRACTICING PHYSICIANS IN ALASKA IN THE LAST SEVERAL YEARS IS AS FOLLOWS:

Year	Active Status	With Alaska Address	New License Issued
1975	474	276	87
1974	No figures available		
1973	410	217	83
1972	373	169	64
1971	356	182	80
1970	276	182	86
1969	240	-	66

8. You may also be interested in the national "premium as percent of income" figures developed by Medical Economics Company, 1972 for self-employed general practitioners and self-employed general surgeons.

PHYSICIANS

Year	Dollar Cost	Index (1966=100)	Premium as Percent of Income
1960	$ 110.7	71.9	NA
1962	114.9	74.6	0.5
1964	133.0	86.4	0.5
1966	154.0	100.0	0.6
1968	249.5	162.1	0.8
1970	620.5	403.0	1.8
1971	711.5	462.1	NA
1972	767.2	498.3	NA

SURGEONS

Year	Dollar Cost	Index (1966=100)	Premium as Percent of Income
1960	229.1	52.3	NA
1962	279.1	63.7	NA
1964	378.1	86.2	1.2
1966	438.5	100.0	1.2
1968	571.0	130.2	1.4
1970	1,880.9	428.9	4.2
1971	2,094.0	477.5	NA
1972	2,307.4	526.2	NA

NA = Not Available

As mentioned earlier, the income of Alaskan physicians has not been compiled and, therefore, average premiums cannot at this time be related to average income.

LC:jm

QUESTIONS CONCERNING MALPRACTICE INSURANCE CRISIS

TO BE DIRECTED TOWARD MR. RICHARD BLOCK,

COMMISSIONER OF INSURANCE

1. The mandating of all of the hospitals and doctors in the State into an insurance "pool" is based on the premise that this will provide an attractive package for the insurance industry. Since there are fewer doctors and hospital beds in the entire State of Alaska than in even one section of a metropolitan area in the lower 48, please explain why an insurance company would find our package attractive, when large segments of the lower 48 are having acute insurance problems? They won't period.

2. Please supply specific details on which, if any, companies have committed themselves to the entire Commission package; what sort of ball park premium rates are envisioned as being "affordable"; and specifically, what efforts have been made to ascertain this information? None

3. You have been quoted as stating that a plan insuring only those currently without insurance would provide adverse experience at the outset. Many physicians whose insurance has been summarily cancelled after many years without a claim doubt the valadity of this statement and challenge you to prove that the claims experience of Alaskan doctors currently insured is significantly better than those who are not?

4. Many of the Commission points were based on the belief that the "Alaskan experience" is better than experience in the lower 48. Since Alaska is being inundated with "nonAlaskans" many physicians believe that the future Alaskan experience will be no better and possibly worse than the lower 48 experience.

5. A tax on physicians gross income is under active consideration as a basis for "premium" determination. As this would bear no relationship to risk factors and, in different garb, would be called a piece of the action, house cut, protection money, etc., how do you fit such a tax into broad insurance concepts?

6. It has been repeatedly asserted than mandatory participation of all of the States physicians and hospitals is necessary for actuarial soundness. Please provide firm statistical evidence: a) that any meaningful data can be derived in the forseeable future, considering the huge variation qualitatively within our small population of physicians and hospitals and the equally huge variation to be expected both qualtitative and quantitatively in any potential claims; b) that the chance current physician population to be mandated into the plan somehow, coincidentally, represents the minimum sample population which would be actuarily sound.

file Malpractice

Ketchikan Medical Society

3100 Tongass Avenue - Ketchikan, Alaska 99901

March 29, 1976

Representative Terry Gardiner
Pouch V
Juneau, Alaska 99801

Dear Terry:

I am writing in reference to your activities on the combined select committee on the malpractice legislation. I would like to let you know about our priorities and feelings concerning the issues yet to be decided in your committee.

Of all the issues yet to be decided, we believe the advisory panel concept is the most important. This would represent a true departure from the current situation, and offers patients the real possibility of early resolution of cases at the least expense, leaving the bulk of malpractice insurance premiums for injured patients, which is where they ought to go. Except where cases involved health care providers other than physicians, physicians should make up the panel.

Secondly, we strongly urge that language be refined to spell out very clearly the increased powers given the respective boards. Specifically, we support the changes in terminology offered by the medical association lobbyists in their March 15th releases. A copy of that paragraph is attached.

Thirdly, we favor sharpening the list of questions to be answered by the advisory panel. Again, I have attached the specific language previously offered by the medical association lobbyists.

Fourthly, we believe that basing malpractice premiums in considerable degree on medical revenues is the most realistic. A net medical income basis would avoid penalizing high overhead practices.

We support the concepts of toughening the licensing boards, clarifying informed consent and requiring participation in the insurance program. While there are further reforms we would like to see that are not included, we are pleased that the legislature is addressing this problem.

Thank you for your leadership.

Yours truly,

Dave

David E. Johnson, M.D.
President
Ketchikan Medical Society

SUGGESTED CHANGES TO CSHB 574

Firmer deliniation of responsibilities of professional board of examiners:

> That by reason of demonstrated deficiency of competence, experience, or education, or because of physical or mental illness, the authority to practice should be limited or conditioned or the practitioner disciplined, the board may reprimand, censure, place on probation, restrict practice, require further formal education approved by the board, or may suspend or revoke the license.

More specific listing of questions for advisory board:

(1) What was the disorder for which the person sought medical care?
(2) What would have been the outcome without medical care?
(3) Was the treatment selected appropriate for the case?
(4) Did an injury arise from the medical care?
(5) What is the injury?
(6) How extensive and how disabling is the injury?
(7) Is the injury stable; or will it improve or become worse?
(8) What specifically caused the injury?
(9) Was the injury the result of negligent medical care?
(10) Is the outcome different than would otherwise have been expected?

Supplement to the Report to the Legislature of the State of Alaska on Medical Malpractice Proposals

by Dr. Herbert S. Denenberg
P. O. Box 146
Wynnewood, Pa. 19096

(Initial Report Dated December 4, 1975 and presented in Juneau, Alaska on December 9 and in Anchorage on December 10, 1975)

February 20, 1976

1. On December 9, 1975, I met in Juneau, Alaska with a group that included Representative Mike Miller, Vice Chairman of the Legislative Council, Senator John Huber, Representative Fred Brown, Representative Larry T. Davis and staff members.

2. The next day I had a series of meetings with various members of the legislature, including Senator Chancy Croft, Senator Jalmar M. Kertulla, Senator Patrick Rodey, Representative Fred Brown, Representative Larry Davis, Representative Samuel R. Cotten, Representative Kathryn Ostrowsky, Representative Charles Parr, and staff members. In addition I talked to members of the Judiciary Committee before their meeting on Rent Control. Those attending, in addition to members of the legislature, included some members of the Governor's Commission on Medical Malpractice and other members of the public.

3. In the course of these meetings, and other informal discussions with members of the legislature, I made a series of comments and recommendations, which do not appear in my report. Some of these additional remarks are briefly summarized here to serve as a supplement to my initial report dated December 4, 1975. I have also included my response to several questions raised by members of the legislature.

4. The law of Alaska should be clarified so any advance payments on malpractice or other claims would not be considered an admission of liability and would be deducted from any final judgment.

Indiana, Louisiana, Nebraska, Nevada and Wisconsin have passed laws relating to this matter. Nebraska (Legislative Bill 560, passed in 1975) provides any advance payment will not be an admission of liability, and further that: "In the event of a trial involving such a claim, the fact that such payments have been made shall not be admissible in evidence or brought to the attention of the jury, and the matter of any credit to be deducted from a judgment shall be determined by a court in a separate hearing or upon the stipulation of the parties."

This should encourage early payment on claims, early settlements, and attempts to minimize damages by early medical treatment. (A similar approach has been suggested in the report on no-fault as to auto liability claims.)

5. Mandatory arbitration should be considered to provide a more economical determination of cases and a sweeping out of some of the flimsy claims. This would not impair the right to trial by jury as there would be a right of appeal de novo to the courts.

6. The Governor's Commission recommended legislation (p.15, sec.9.55.540(c)) subjecting claims more than three years old to a higher standard of proof than would be otherwise imposed on civil claims. This appears to be an unfair and unreasonable requirement, and any attempt to apply such a standard would probably create more confusion and problems than it would dispel.

7. Senator Huber asked me to comment on a provision in the crime compensation act making attorney's fees an addition to any award. This is certainly a sound provision and will help assure that any damages assessed will not be diverted immediately from the purposes for which they are awarded.

Whether this kind of provision is essential depends on the kind of compensation program being considered. For example, in workmen's compensation, the law may be designed to make sure the worker can collect without the need for a lawyer. If this is the case and if the assumption is sound, paying for all attorney fees may simply bring in lawyers needlessly and increase costs.

The National Commission on State Workmen's Compensation Laws had this to say on attorney fees: "An additional question is whether the employee or the employer should pay the employee's attorney's fee. With the adoption of our recommendations for improvements in the delivery system and the adequacy of benefits, it is not unreasonable to hold the employee primarily responsible for any attorney's fees that he incurs. However, States should consider the shifting of these fees to the employer as a form of penalty in those cases in which the employer or his insurer has acted in an unjustified manner."

This view of the National Commission is not entirely logical. Even if benefits are adequate, they will be rendered inadequate by deduction of attorney's fees.

The National Commission of Malpractice also considered the question of attorney's fees. It recommended regulating the contingent legal fee by establishing a scale in which the fee decreases as the recovery amount increases (a similar recommendation appears in my earlier report on malpractice).

Here, too, recoveries, if properly determined, will be rendered inadequate by deduction of attorney's fees. However, some believe juries tend to pad awards to cover legal expenses.

Ideally, recovery should include actual damages as well as expenses of litigation. To do so would increase the cost of malpractice insurance. It would also raise the question of charging the plaintiff with the defendant's attorney's fees in cases which the defendant won. All of this would introduce further uncertainties into the litigation process, and perhaps make the right to a day in court even more difficult to obtain.

Although the addition of attorney's fees in another context may be entirely appropriate, it is not clear that in the malpractice field this would be a wise practical measure.

There would be general agreement that requiring the payment of attorney's fees in cases in which there is unreasonable failure to pay benefits (or other unjustified action) is an appropriate measure. This kind of provision can be found in workmen's compensation laws. There, it has practical value, as most cases are clear cut with no room for argument, but in malpractice cases few claims are so clear cut, so the provision would have little practical value.

8. Representative Parr asked me to comment on how the malpractice system could be changed to make it possible for a small but meritorious claim to be collected. In small malpractice claims, it may not pay an attorney to handle the matter on a contingent fee basis. The National Commission on Medical Malpractice found cases in which claimants had to abandon a case which might be worth $10,000 because even such a meritorious case did not offer adequate incentive to an attorney working on a contingent fee basis (See p. 35 of National Malpractice Commission Report).

The only remedy the National Commission could suggest is to establish "public legal assistance mechanisms" or to expand those that already exist "to assure adequate legal representation to persons with small malpractice claims."

The ready availability of arbitration may somewhat ease the problem. Another suggestion is to establish small claims courts presided over by those technically proficient in the area of medical legal malpractice. In other words, this would be a special small claims court for malpractice claims.

There is probably no good answer for this problem at the present time. Perhaps at one point no-fault malpractice compensation systems will become practical, and enable small meritorious malpractice claims to be adequately compensated.

338

196858
FILE NUMBER

DOMESTIC

STATE OF WASHINGTON | DEPARTMENT OF STATE

I, A. LUDLOW KRAMER, Secretary of State of the State of Washington and custodian of its seal, hereby certify that

RECEIVED
APR 11 1969
Alaska Division
of Insurance

AMENDED
ARTICLES OF INCORPORATION

of WASHINGTON HOSPITAL SERVICE ASSOCIATION

a domestic corporation of Seattle, Washington,

(Amending Article II (purposes) and Article V (directors); and changing name to BLUE CROSS WASHINGTON-ALASKA, INC.)

was filed for record in this office on this date, and I further certify that such Articles remain on file in this office.

FILED FOR RECORD

Apr 11, 1969

State of Alaska
Division of Insurance
By # 31209
BH

In witness whereof I have signed and have affixed the seal of the State of Washington to this certificate at Olympia, the State Capitol,

March 24, 1969.

A. LUDLOW KRAMER
SECRETARY OF STATE

APPROVED
AS TO FORM AND MANNER
MAR 24 1961
A. LUDLOW KRAMER
SECRETARY OF STATE
BY
CORPORATION SECRETARY

AMENDED ARTICLES of INCORPORATION

of

WASHINGTON HOSPITAL SERVICE ASSOCIATION

STATE OF WASHINGTON)
) SS
COUNTY OF KING)

WE, the undersigned, the President and Secretary respectively, of WASHINGTON HOSPITAL SERVICE ASSOCIATION, hereby certify that, at a special meeting of the members of the Washington Hospital Service Association called for the purpose of amending the Articles of Incorporation, notice of which was given in the manner provided in the By-laws for the election of Trustees and more than two-thirds of all of the members voted to amend the following articles of the Articles of Incorporation to read as follows:

ARTICLE I.

"Name: The name of this corporation shall be:

BLUE CROSS WASHINGTON-ALASKA, INC.

ARTICLE I I.

Purpose: The particular business and object of the corporation shall be to establish, maintain and operate, with no individual being entitled to any of the net income thereof, a non-profit hospital service plan whereby hospital care shall be provided to persons who become subscribers to the plan of the corporation under contract entitling each subscriber to certain hospital care by and at the hospitals with which the corporation may from time to time contract, to contract with such hospitals as may be approved and selected by the

Board of Directors for the purpose of acting as their agent, to provide hospital care to the subscribers of the plan; to promote the general and social welfare of such persons as may become subscribers of the plan, and to do all things necessary, proper or convenient for the purpose of promoting, establishing and operating such non-profit hospital service plan, to furnish to individuals, on a non-profit basis, prepaid medical, surgical, dental, other therapeutic services and home nursing care by this corporation, through any means found desirable, including but not limited to this corporation, entering into contractual relations with, corporations, firms, associations or individuals who or which furnish such prepaid medical, surgical, dental, other therapeutic services and/or home nursing care on a prepayment for services or indemnity basis, or furnish insurance covering such medical, surgical, dental, other therapeutic services or home nursing care; to act as agent for such corporation, firm, association or individual, and to do all things necessary, proper or convenient, in connection therewith."

ARTICLE V.

"Directors: The number of Directors shall be not less than five nor more than twenty-five, as shall be determined from time to time by the Board of Directors and the names of the Board of Directors who shall manage the affairs of the corporation until the next annual meeting of the corporation shall be:

Don J. Robbins	Pacific Northwest Bell Company 1616 Exchange Building Seattle, Washington 98104
Robert N. Rabideau	Overlake Memorial Hospital 1035 - 116th N.E. Bellevue, Washington 98004
Walter L. Huber	Tacoma General Hospital 315 South "K" Street Tacoma, Washington 98405
Theodore E. McCaffray	National Fruit Canning Company P. O. Box 9366 Seattle, Washington 98109
Irving S. Smith	Continental, Inc. 701 Second Avenue Seattle, Washington 98104

Elmer A. Hill	Seattle General Hospital Fifth & Marion Seattle, Washington 98104
Sister Georgette Jean	St. Elizabeth Hospital 110 South Ninth Avenue Yakima, Washington 98902
William E. Murray	Valley General Hospital 4th & Shattuck Renton, Washington 98055
Sister Barbara Ellen	Providence Hospital 3200 Providence Drive Anchorage, Alaska 99504
Fred Hulcen	The Boeing Company P.O. Box 3707 Seattle, Washington 98124
C. J. Kretchmer	Blue Cross Washington-Alaska, Inc. P.O. Box 327 Seattle, Washington 98111
Willis Parr	Skagit Valley Hospital 1415 Kincaid Street Mount Vernon, Washington 98273
Sister Virginia Schwager	Providence Hospital 17th & East Jefferson Seattle, Washington 98122
Larry D. McIntyre	Prosser Memorial Hospital Prosser, Washington 99350
Sister Xavier Richardson	St. Ignatius Province East 9 Ninth Avenue Spokane, Washington 99202
George H. Stone	Children's Orthopedic Hospital 4800 Sandpoint Way Seattle, Washington 98105
John A. Dare	Virginia Mason Hospital 1111 Terry Avenue Seattle, Washington 98101
C. Grover Wilson	811 West 26th Avenue Spokane, Washington 99202
Thomas L. McQuaid	1220 Dexter-Horton Building Seattle, Washington 98104
John W. Kludt	St. Luke's General Hospital 809 East Chestnut Bellingham, Washington 98225
Eugene W. Pray	Columbia Basin Hospital Ephrata, Washington 98823
Rev. Lawrence Willenborg	St. Vincent dePaul Parish 30525 - 8th Avenue South Federal Way, Washington

Harold E. Silvernail	Edmonds School District No. 15 3800 - 196th S.W. Lynnwood, Washington
Rev. Chester Finkbeiner	Central Washington Deaconess Hospital Okanogan & Kittitas Streets Wenatchee, Washington 98801
Charles Y. McGarrigle	Puget Power P.O. Box 329 Renton, Washington 98055
Robert W. Bradley	Harrison Memorial Hospital 2520 Cherry Street Bremerton, Washington 98310

WASHINGTON HOSPITAL SERVICE ASSOCIATION

S/ _____
Don J. Robbins, President

S/ _____
Theodore E. McCaffray, Secretary

SUBSCRIBED AND SWORN TO before me this 14 day of March, 1969.

_____
Notary Public in and for the State of Washington
residing at Seattle

FILED FOR RECORD
SECRETARY OF STATE
TERRITORY OF ALASKA
NOV 28 1932
NEIL F. MOORE - Auditor

ARTICLES OF INCORPORATION

OF

WASHINGTON HOSPITAL SERVICE ASSOCIATION

Know All Men By These Presents:

That we, Walter Heath, Howard C. Ries, A. L. Holberg, Sister Mary of the Cross, Herina I. Eklind, Ethel V. Soper, Mother M. Teresa, and John A. Dare, desiring to organize a corporation not formed for profit, as provided by the laws of the State of Washington under Remington's Revised Statutes, sections 3888 to 3900, and for the promotion of social welfare, hereby associate ourselves and adopt, in triplicate, the following Articles of Incorporation:

ARTICLE I.

Name: The name of this corporation shall be:

WASHINGTON HOSPITAL SERVICE ASSOCIATION.

ARTICLE II.

Purpose: The particular business and object of the corporation shall be to establish, maintain and operate, with no individual being entitled to any of the net income thereof, a non-profit hospital service plan whereby hospital care shall be provided to persons who become subscribers to the plan of the corporation under contract entitling each subscriber to certain hospital care by and at the hospitals with which the corporation may from time to time contract, to contract with such hospitals as may be approved and selected by the Board of Trustees for the purpose of acting as their agent, to provide hospital care to the subscribers of the plan; to promote the general and social welfare of such persons as may become subscribers of the plan and to

do all things necessary, proper or convenient for the purpose of promoting, establishing and operating such non-profit hospital service plan.

ARTICLE III.

Principal Place of Business: The principal place of business of this corporation shall be in Seattle, King County, Washington.

ARTICLE IV.

Term of Existence: The term for which this corporation is to exist is fifty years.

ARTICLE V.

Trustees: The number of Trustees shall be not less than five nor more than twenty-five, as shall be determined from time to time by the Trustees, and the names of the Trustees who shall manage the affairs of the corporation until September 15, 1945 shall be:

Names	Addresses:
Dr. Herbert Coe	Summit & Madison, Seattle, Washington
Dr. C. W. Knudson	Seattle General, " "
Herina I. Eklind	Swedish Hospital, " "
Sister Brendon	Sacred Heart Hospital, Spokane,"
Sister Maria of Providence	Providence Hospital, Seattle, "
Sister Joan Marie	St. Joseph's Hospital, Bellingham, Washington
Sister Mary Jane	" " " Tacoma, Washington
Mother M. Teresa	Columbus Hospital, Seattle, Washington
Rev. Cornelius Harrington	Seattle, Washington
John A. Dare	Virginia Mason Hospital, Seattle, Washington
A. L. Howarth	Deaconess Hospital, Wenatchee, Washington
Howard C. Ries	Everett, Washington
Gordon Gilbert	St. Luke's Hospital, Spokane, Washington
Horace Turner	Deaconess Hospital, " "
Dr. H. E. Rhodehamel	Spokane, Washington
Walter Heath	Tacoma General Hospital, Tacoma, Washington
Cecile Tracy Spry	Everett General Hospital, Everett, Washington
A. L. Holberg	Maynard Hospital, Seattle, Washington
Sister Providence of the Sacred Heart	St. Elizabeth's Hospital, Yakima, Washington

IN WITNESS WHEREOF, we, the undersigned, being each of the original incorporators hereinbefore named, for the purpose of forming a

corporation to do business within the State of Washington, do make and file these Articles of Incorporation, hereby certifying and declaring that the facts herein stated are true and, accordingly, have hereunto set our hands and seals this 4th day of May, 1945.

Walter Heath

Howard C. Ries

A. L. Holberg

Sister Mary of the Cross

Herina I. Eklind

Mother M. Teresa

Ethel V. Soper

John A. Dare

State of Washington,)
: ss
County of King)

THIS IS TO CERTIFY that before me, the undersigned notary public in and for the State of Washington, duly commissioned, sworn and qualified, personally appeared the above named incorporators: Walter Heath,

Howard C. Ries, A. L. Holberg, Herina I. Eklind, Ethel V. Soper, Mother M. Teresa and John A. Dare, to me personally known to be the individuals who signed the foregoing Articles of Incorporation, and jointly and individually acknowledged to me that they signed and sealed the same as their free and voluntary act and deed for the uses and purposes therein mentioned.

GIVEN under my hand and seal of office this 4th day of May, 1945.

Lewis L. Stedman
Notary Public in and for the State of Washington, residing at Seattle.

State of Washington,)
: ss
County of)

THIS IS TO CERTIFY that before me, the undersigned notary public in and for the State of Washington, duly commissioned, sworn and qualified, personally appeared Sister Mary of the Cross, one of the above named incorporators, personally known to me to be one of the individuals who signed the Articles of Incorporation and who acknowledged to me that she signed, sealed and executed the same as her free and voluntary act and deed for the uses and purposes therein mentioned.

GIVEN under my hand and seal of office this 8th day of May, 1945.

Lewis L. Stedman
Notary Public in and for the State of Washington, residing at Seattle.

AMENDED ARTICLES OF INCORPORATION

of

WASHINGTON HOSPITAL SERVICE ASSOCIATION

We, Howard C. Ries and Sister Maria of Providence, president and secretary, respectively, of the Washington Hospital Service Association, do hereby certify that at a special meeting of said Association held June 30, 1947, at which meeting more than two-thirds of its members were present in person or by proxy, by resolution duly made, seconded and unanimously adopted, Article II of the Articles of Incorporation of said Association was amended to read as follows:

Article II.

Purpose: The particular business and object of the corporation shall be to establish, maintain and operate, with no individual being entitled to any of the net income thereof, a non-profit hospital service plan whereby hospital care shall be provided to persons who become subscribers to the plan of the corporation under contract entitling each subscriber to certain hospital care by and at the hospital with which the corporation may from time to time contract, to contract with such hospitals as may be approved and selected by the Board of Trustees for the purpose of acting as their agent, to provide hospital care to the subscriber of the plan; to promote the general and social welfare of such persons as may become subscribers of the plan, and to do all things necessary, proper or convenient for the purpose of promoting, establishing and operating such non-profit hospital service plan, to furnish to individuals, on a non-profit basis, prepaid medical surgical and home nursing care by this corporation, through any means found desirable, including but not limited to this corporation entering into contractual relations with, corporations, firms, associations, or individuals who or which furnish such prepaid medical, surgical and/or home nursing care on a prepayment or indemnity basis, or furnish insurance covering such medical, surgical or home nursing care; to act as agent for such corporation, firm, association or individual, and to do all things necessary, proper or convenient in connection therewith.

Dated at Seattle, Washington, this June 30, 1947.

Howard C. Ries
President

Sister Maria of Providence
Secretary

State of Washington,)
: ss
County of K i n g.)

Howard C. Ries, as president of the Washington Hospital Service Association, being first duly sworn on oath deposes and says:

That the foregoing copy of Article II of the Article of Incorporation of Washington Hospital Service Association is a full, true and correct copy of such Article II, as amended, as duly adopted by a vote of more than two-thirds of the members of said Association at a special meeting duly called for the purpose of so amending the Articles of Incorporation, notice of which meeting was given in the manner provided by the By-Laws of the Association for the giving of notices and election of trustees.

Howard C. Ries

Subscribed and sworn to before me this June 30, 1947.

G. P. Locker
Notary Public in and for the State of Washington, residing at Seattle.

State of Washington,)
: ss
County of Clark)

Sister Maria of Providence, as secretary of the Washington Hospital Service Association, being first duly sworn on oath deposes and says:

That the foregoing copy of Article II of the Articles of Incorporation of Washington Hospital Service Association is a full, true and correct copy of such Article II, as amended, as duly adopted by a vote of more than two-thirds of the members of said Association at a special meeting duly called for the purpose of so amending the Articles of Incorporation, notice of which meeting was given in the manner provided by the By-Laws of the Association for the giving of notices and election of trustees.

Sister Maria of Providence

Subscribed and sworn to before me this 7th day of July 1947.

Claire Lewis
Notary Public in and for the State of Washington, residing at Camas

I, Herina I. Eklind, Secretary of the Washington Hospital Service Association do certify that the foregoing are true copies of the By-Laws of the Washington Hospital Service Association and the amended By-Laws of the Washington Hospital Service Association.

Signed H. Herina I. Eklind

THE ALASKA CLINIC
A PROFESSIONAL CORPORATION
825 L STREET
ANCHORAGE, ALASKA 99501
907-279-0622

November 17, 1975

DEPARTMENT OF INTERNAL MEDICINE
GARY ARCHER, M.D.
DALE I. WEBB, M.D.
W.B. BEACHAM, M.D.
ANNE M. MORRIS, M.D.
GERALD G. MORRIS, M.D.
RICHARD A. ANSENHERTZ, M.D.

SECTION OF NEUROLOGY
JANICE HASTELLA, M.D.

SECTION OF PSYCHIATRY
ROBERT MC MAHON, M.D.
DONALD A. PEIGIN, M.D.
ROYAL P. RIEHL, M.D.

DEPARTMENT OF FAMILY AND INDUSTRIAL MEDICINE
VERNON A. GATES, M.D.
TRYON S. WIELAND, M.D.
JERRY LITTLE, M.D.
ROBERT SCIVELL, M.D.
GILBERT S. DICKIE, M.D.
THOMAS S. WILSON, M.D.
JANICE BARRY, M.D.
D.E. MELVILLE, M.D.

DEPARTMENT OF GENERAL THORACIC AND VASCULAR SURGERY
SAM DE PALATIS, M.D.
DAVID M. GIETZ, M.D.

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY
BURNETT W. NEWTON, M.D.
WILLIAM H. IVY, M.D.
RICHARD W. CURTIS, M.D.
JERRY GREEN, M.D.
GEORGE STRANSKY, M.D.

DEPARTMENT OF ORTHOPAEDIC SURGERY
JOHN O. PROBY, M.D.

DEPARTMENT OF PATHOLOGY
DONALD R. ROGERS, M.D.
MICHAEL T. PROBY, M.D.

DEPARTMENT OF PEDIATRICS AND ADOLESCENT MEDICINE
WILLIAM M. LARSON, M.D.
ALAN HENDRICKSON, M.D.
PHYLLIS S. RIEHL, M.D.

DEPARTMENT OF UROLOGIC SURGERY
HERBERT BIAS, M.D.

DEPARTMENT OF EMERGENCY SERVICES
ALEXANDER SUDELMAN, M.D.

DEPARTMENT OF ADMINISTRATION
MAX HERSCHBERGER, ADMINISTRATOR
JAMES HOOKER, BUSINESS MANAGER

Governor Jay Hammond
Juneau,
Alaska

Dear Governor Hammond:

The Alaska Clinic has been criticized by some in the medical community for failing to take a stand regarding the recent malpractice insurance problem. The Clinic has adequate insurance from a commercial carrier and in addition, is currently negotiating with another company for even more favorable coverage. Therefore, we are not as urgently affected as are some of our colleagues. This is not to say that we are ignorant of, or insensitive to the problem which is nationwide in scope. We, too, feel that the present system of handling malpractice claims has evolved into an unworkable one and that some fundamental change is essential. We have felt that the actions of some local physicians have been ill-advised and counter-productive. We have elected to remain silent until specific proposals are available for consideration. Since the Governor's commission has now made its recommendations available, we will break our silence.

The principle of making malpractice risks more predictable is obviously valid and, therefore, we support the concept of a more reasonable statute of limitations, reduction of awards by collateral sources of compensation, requiring "clear and convincing" evidence of negligence, periodic versus lump-sum payments, establishment of professional review boards to evaluate claims out of court, strengthening of the disciplinary functions of the State Licensure Board, and limiting contingency fees by lawyers to a reasonable level. These measures alone could make Alaska more attractive to insurance companies and would greatly help to restore a measure of justice to the currently chaotic situation.

The Clinic is opposed to the creation of a "Health Care Providers Indemnity Corporation", membership in which would be mandatory. This provision might benefit solo practitioners, but at great expense to group practices. It is

conceivable that a state-created monopoly could result in very high premiums. It should be noted that group practices have a risk record that has allowed them to remain insured while those in solo practice are losing their coverage. It would be grossly unfair to require groups to give up their reasonably-priced policies to join such a corporation.

The Clinic is also opposed to the creation of a "Late Claims Fund", to be financed by a tax on gross billings. This approach would result in wide variation of actual contributions since net income is so variable among the specialties and between groups and soloists. It should be noted that The Alaska Clinic is intimately associated with a general hospital and provides laboratory and x-ray services to that hospital at cost. This greatly increases the gross billings of the Clinic, but the increase is not reflected in our net. The creation of such a fund on that basis would necessitate substantial increases in both professional fees and hospital room rates. If such a fund is deemed essential, the contribution should be assessed in a manner directly proportional to risk, as is the case with other forms of liability coverage. Again, however, mandatory membership is unfair since most groups have occurrence-type policies which give continual protection thus making participation in such a fund unnecessary. Mandatory involvement in such a scheme might even be found unconstitutional.

The Clinic is also opposed to the concept of a JUA which, even if deemed legal, does not seem reasonable from the standpoint of insurance companies which, after all, are profit making organizations operating in a supposedly free-enterprise system. They should not be forced into unprofitable business ventures by government.

The Clinic would support the development of a mechanism embodying those principles alluded to in paragraph #2, which would assure reasonable compensation to patients truly injured by genuine physician negligence, which would operate in the free-enterprise system, which would be funded by premiums based on risk, and which would incorporate procedures designed to minimize the burden on the legal system.

Sincerely yours,

Donald R. Rogers, M.D.

DRR/ds

THE ALASKA CLINIC
A PROFESSIONAL CORPORATION
825 L STREET
ANCHORAGE, ALASKA 99501
907-279-0622

January 21, 1976

DEPARTMENT OF INTERNAL MEDICINE
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DEPARTMENT OF EMERGENCY SERVICES
ALEXANDER DUBELMAN, M.D.

DEPARTMENT OF ADMINISTRATION
MAX KERSBERGEN, ADMINISTRATOR
JAMES KOONCE, BUSINESS MANAGER

Representative Terry Gardiner
Chairman, House Judiciary Committee
State Capitol
Pouch V
Juneau, Alaska 99811

Dear Mr. Gardiner:

As we discussed on the phone earlier today, the physicians who belong to the larger groups in Anchorage, Fairbanks and Soldotna are opposed to mandatory inclusion into any proposed State sponsored medical malpractice insurance plan. While I cannot document this statistic, our insurance carrier assures us that group practices have a much better record regarding incidence of lawsuits. This facts allows us to buy insurance at a reasonable rate even when some soloists cannot acquire it at any cost. We feel it unfair to us and to our patients (who ultimately pay for it) to be forced to subsidize the soloists. While this may sound insensitive, our feeling is that any plan which manipulates only the insurance rates will not solve the basic problem - that of the manner in which tort law is applied. If reform in that area were to come about, the insurance industry would probably be able to function in the traditional fashion.

I believe that two members of the ASMA have lobbied in favor of the mandatory provisions of the Commissioner's plan giving the impression that support is unanimous among Alaska physicians. I think that I speak for approximately one-third of the doctors in the State in opposition to these provisions (the third who continued to work during last summer's slow down).

I would appreciate it if you would share these thoughts with your committee members. Enclosed is a copy of a letter which I wrote to the Governor late last year which amplifies somewhat.

Sincerely yours,

Donald R. Rogers, M.D.
President, Board of Directors

DRR/ds