HB

522

HOUSE
COMMITTEE REPORT

(7)
Date referred: 1/29/86

FURTHER REFERRALS: JUDICIARY

DATE: Apr. 14, 1986

The LABOR & COMMERCE Committee has considered HB 522

"An Act relating to unfair insurance claims settlement practices; and providing for an effective date."

and recommends:

[x] do pass
[ ] do not pass
[ ] do pass with attached amendment(s)
[ ] no recommendation
[x] replace with CS HB 522 (L+C) [ ] same title
[x] new title
and recommends do pass
[ ] further referral to the ______ Committee

and attaches:
[ ] letter of intent
[ ] first fiscal note
[ ] new fiscal note
[✓] zero fiscal note

SIGNING DO PASS:

Mike Navarre
[signature]
[signature]

SIGNING OTHER RECOMMENDATIONS:

Joyce Hanley - No Rec
[signature]

Mike Navarre
Chairman

Department of Commerce & Economic Development / POSITION PAPER

CSHB 522(L&C): "An Act relating to payment of insurance premiums, cancellation of insurance policies, and the provision of medical malpractice insurance for nurse midwives; and providing for an effective date."

The Department favors passage of this proposed legislation.

Sections 1 & 2 of this bill would provide that, for purposes of receiving payment of an insurance premium, a broker is legally considered an agent of the insurance company. This legislation does not give the broker the ability to bind coverage with an insurance company that has not given him that authority. The insurance agent has a direct contractual relationship with the insurance company in which it places business. The effect of this is that when an agent receives premium from an insured, it is the same as though the insurance company had received the funds, even if the insurance company never receives the money.

The situation with a broker is not as clear. The broker by definition represents the insured, not the insurance company. While it is possible that a legal argument could be made to attempt to treat the broker as an agent of the insurer, this must be done in court on a case by case basis.

During the past two years, it has become clear that a similar law is needed for brokers. Two large broker insolvencies have occurred where insureds have paid the broker who in turn has failed to remit those funds to the insurer resulting in cancellation of coverage for nonpayment of premium. The insured then suffers a loss of coverage and monies. In most cases, the insured person did not know in which capacity the producer was acting, let alone understand and appreciate the distinction.

Sections 3 - 10 and 14 address cancellation of commercial insurance policies. Under existing law, there is a limitation on cancellation of personal lines policies such as automobile insurance policies and homeowners insurance policies. A part of this law also establishes minimum amounts of time when a cancellation is issued and requires a reason for any cancellation or nonrenewal of coverage. These minimums and reasons do not currently apply to business or commercial policies.

This proposal will provide for a 60 day notice time that a company must give when it cancels an insurance policy, other than personal lines of insurance. It also requires that any unearned premium shall be returned prior to the effective date of cancellation unless cancellation is for nonpayment of premium.

The need for this request arises from the tightening insurance markets. As companies are reducing the amount of insurance they are writing, they are eliminating entire classes of insurance from their book of business and they are often cancelling policies of those insureds who have suffered losses. The Alaskan consumer needs adequate notice in order to be able to find an alternate insurer in the event that his policy is cancelled.

To accomplish this, it is necessary to substantially rearrange AS 21.36.210 - AS 21.36.310. The changes do not revise the impact of those sections of law on personal lines. It does make some of those provisions applicable to business or commercial insurance.

We recommend that the notice period for a nonpayment cancellation remain unchanged. This means removing the change made on page 3, line 24. and changing the 20 days on page 4, line 4 to read 10 days. The logic for this is that a person about to receive notice for nonpayment generally knows that payment has not been made. 10 days is adequate.

Sections 11 - 13 provide that nurse midwives can purchase medical malpractice insurance from the Medical Indemnity Corporation of Alaska (MICA). This will provide an additional market that the nurse midwife would have available if required. We would recommend that Section 11 on page 7, lines 9 - 29 be omitted. There are 1200 physicians licensed by the state who are conceivably eligible for coverage from MICA while there are only 21 licensed nurse midwives who might be eligible for coverage from MICA with passage of this bill. That is not a reasonable basis for changing the makeup of the governing board of MICA. This feature should remain unchanged.

Loren H. Lounsbury, Commissioner
Department of Commerce & Economic Development

Date: 4/14/86

John L. George, Director of Insurance

Date: 4/14/86

Ford
4/7/86

Original sponsors: Sund, Koponen, and Gruenberg

IN THE HOUSE

BY THE LABOR AND COMMERCE COMMITTEE

CS FOR HOUSE BILL NO. 522 (L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to payment of insurance premiums, cancellation of insurance policies, and the provision of medical malpractice insurance for nurse midwives; and providing for an effective date."

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

* Section 1. AS 21.27.200(a) is amended read:

(a) Except as provided in (c) of this section,

(1) a [A] broker, as such, is not an agent or other representative of an insurer, and does not have power as a broker to bind the insurer upon any risk or with reference to any insurance contract; and

(2) nothing [. NOTHING] in this section is intended to alter the common law of agency as applied to transactions under this title.

* Sec. 2. AS 21.27.200 is amended by adding a new subsection to read:

(c) For purposes of determining an insured's entitlement to coverage, a premium paid to the broker is considered to be received by the insurer, if the payment to the broker is designated for specific coverage from a specifically named insurer and is supported by competent evidence.

* Sec. 3. AS 21.36.210(a) is amended to read:

(a) An insurer may not exercise its right to cancel a policy of personal [AN] automobile insurance [POLICY] except for the following reasons:

(1) nonpayment of premium; or

(2) the driver's license or motor vehicle registration of either the named insured or of an operator who resides in the same household as the named insured or who customarily operates a motor vehicle insured under the policy has been under suspension or revocation during the policy period or, if the policy is a renewal, during its policy period or the 180 days immediately preceding its effective date.

* Sec. 4. AS 21.36.210(d) is amended to read:

(d) This section does not apply to

(1) the failure to renew a policy, except as to coverage in force for less than 12 months;

(2) a policy that has been in effect less than 60 days at the time notice of cancellation is mailed or delivered by the insurer, unless it is a renewal policy;

(3) a policy issued under an automobile assigned risk plan or automobile insurance plan;

(4) a policy insuring more than four motor vehicles;

(5) a policy covering the operation of a garage; automobile sales agency, repair shop, or service station; or public parking place;

(6) a policy providing insurance only on an excess basis;

(7) any other contract providing insurance to the named insured, even though the contract may incidentally provide insurance with respect to motor vehicles.

* Sec. 5. AS 21.36.210(f) is amended to read:

(f) An [NOTWITHSTANDING (e) OF THIS SECTION, AN] insurer may not exercise its right to cancel a policy of personal insurance other than personal automobile insurance, except for the following reasons [THE

TYPE DESCRIBED IN (e) OF THIS SECTION IF ONE OF THE FOLLOWIN CONDITIONS OR CIRCUMSTANCES ARISES]:

(1) nonpayment of premiums, including nonpayment of addi tional premiums, calculated in accordance with the current ratin manual of the insurer, justified by a physical change in the insure property or a change in its occupancy or use;

(2) conviction of the insured of a crime having as one o its necessary elements an act increasing a hazard insured against;

(3) discovery of fraud or material misrepresentation mad by the insured or a representative of the insured in obtaining th insurance or by the insured in pursuing a claim under the policy;

(4) discovery of a grossly negligent act or omission by th insured that substantially increases the hazards insured against; or

(5) physical changes in the insured property that result i the property becoming uninsurable.

* Sec. 6. AS 21.36.220 is amended to read:

Sec. 21.36.220. NOTICE OF CANCELLATION. An insurer may no exercise its right to cancel a personal insurance policy unless a written notice of cancellation is mailed or delivered to the name insured, at the address shown in the policy, at least 60 [20] day before the effective date of cancellation. However, if [, EXCEPT THA WHEN] cancellation is for nonpayment of premium, the notice must [SHALL] be mailed or delivered to the named insured at the addres shown in the policy at least ~~20~~ 10 days before the effective date o cancellation, and must [SHALL] include or be accompanied by a statement of the reason for the cancellation. [THIS SECTION DOES NO APPLY TO THE FAILURE TO RENEW A POLICY, EXCEPT AS TO COVERAGE IN FORCE FOR LESS THAN 12 MONTHS.]

* Sec. 7. AS 21.36.220 is amended by adding new subsections to read:

(b) An insurer may not exercise its right to cancel a policy o business or commercial insurance unless a written notice of cancella tion is mailed or delivered to the named insured, at the address show in the policy, and to the agent or broker of record, at least 60 day before the effective date of cancellation. However, if cancellatio is for nonpayment of premium, the notice must be mailed or delivere to the named insured at the address shown in the policy and to th agent or broker of record at least ~~20~~ 10 days before the effective dat of cancellation, and must include or be accompanied by a statement o the reason for the cancellation.

(c) If an insurer cancels a policy under (b) of this section, i shall return any unearned premium to the agent or broker of record o directly to the insured or premium finance company, if applicable before the effective date of cancellation, except that, if cancel lation is for nonpayment of premium, any unearned premium must b returned within 45 days after the notice of cancellation is given.

* Sec. 8. AS 21.36.240 is amended to read:

Sec. 21.36.240. FAILURE TO RENEW. An insurer may not fail t renew a personal insurance policy in force for less than 12 months An insurer may not fail to renew a policy [IN FORCE FOR 12 MONTHS O MORE] unless a written notice of nonrenewal is mailed or delivered t the named insured, at the address shown in the policy, at least 2 days for a personal insurance policy, and at least 45 days for business or commercial insurance policy, before the expiration date o the policy[,] or of the anniversary date of a policy written for term longer than one year or with no fixed expiration date. Thi section does not apply

(1) if the insurer has in good faith manifested in any wa its willingness to renew;

(2) in case of nonpayment of premium for the expirin policy; or

(3) if the insured fails to pay the premium as required b the insurer for renewal.

* Sec. 9. AS 21.36.250 is amended to read:

Sec. 21.36.250. NOTICE OF ELIGIBILITY. W[illegible] a policy of automo bile liability insurance is cancelled, other than for nonpayment o premium, or <u>is not renewed in accordance with</u> [FOR FAILURE TO RENEW POLICY OF AUTOMOBILE LIABILITY INSURANCE TO WHICH] AS 21.36.240 [AP PLIES], the insurer shall notify the named insured of possible eligi bility for automobile insurance through the automobile assigned ris plan, or automobile insurance plan. The notification <u>must</u> [SHALL accompany or be included in the notice of cancellation or nonrenewa required by <u>AS 21.36.220</u> [AS 21.36.230] and 21.36.240.

* Sec. 10. AS 21.36.310 is amended to read:

Sec. 21.36.310. DEFINITIONS. In AS 21.36.210 - 21.36.310

<u>(1) "business or commercial insurance" means insuranc other than personal insurance, life insurance, disability insurance title insurance, or an annuity contract;</u>

<u>(2)</u> "nonpayment of premium" means failure of the name insured to discharge when due any obligations of the named insured i connection with the payment of premium on a policy, or any installmen of the premium whether the premium is payable directly to the insure or its agent or indirectly under any premium finance plan or extensio of credit;

<u>(3) "personal automobile insurance" means insurance no related to business or commercial activities, covering</u> [(2) "POLICY' MEANS AN INSURANCE POLICY COVERING THE RISKS AND EXPOSURES LISTED I AS 21.36.210(e) OR AN AUTOMOBILE POLICY THAT INCLUDES] automobile

liability, uninsured/underinsured motorists [COVERAGE, UNINSURE MOTORIST COVERAGE], automobile medical payments [COVERAGE], or automo bile physical damage [COVERAGE], that is delivered or issued fo delivery in this state [INSURING AS THE NAMED INSURED, ONE INDIVIDUA OR HUSBAND AND WIFE RESIDENT OF THE SAME HOUSEHOLD], and under whic the insured vehicles are of the following types only:

(A) a motor vehicle of the private passenger or sta tion wagon type that is not used as a public or livery convey ance, nor rented to others; or

(B) any other four-wheel motor vehicle with a loa capacity of 1,500 pounds or less that is not used in the occupa tion, profession, or busin.ss of the insured, nor used as public or livery conveyance, nor rented to others;

(4) "personal insurance" does not include an annuity con tract or a policy of life insurance, disability insurance, or titl insurance; the term means personal automobile insurance, or insurance covering

(A) loss of or damage to real property that is use predominantly for residential purposes and that does not consis of more than four dwelling units;

(B) loss of or damage to personal property, includin personal effects, household furniture, fixtures and equipment located in not more than four dwelling units; or

(C) legal liability of natural persons for loss of, damage to or injury to persons or property if the insurance does not cover liability arising from or in connection with business or commercial activities;

(5) [(3)] "renewal" or "renew" means

(A) the issuance and delivery by an insurer of a

policy replacing at the end of the policy period a polic previously issued and delivered by the same insurer.

(B) the issuance and delivery of a certificate o notice extending the term of a policy beyond its policy period o term, or

(C) the extension of the term of a policy beyond it policy period or term under a provision for extending the polic by payment of a continuation premium.

* Sec. 11. AS 21.88.030(a) is amended to read:

(a) The corporation shall exercise its powers through a board o governors which is appointed by the governor of the state and con firmed by the legislature. Members of the board of governors shall b Alaska residents as follows:

(1) <u>three</u> [FOUR] physicians licensed in the state an engaged in private practice in the state; no more than two of th physicians shall practice or live in a municipality having a popula tion of more than 100,000, and two of the physicians must be indem nified against loss by reason of liability for an act or omission i the delivery of professional health care by the Medical Indemnit Corporation of Alaska;

<u>(2) one nurse midwife licensed in the state and engaged i private practice in the state;</u>

<u>(3)</u> an administrator or senior executive officer employe by a hospital licensed in the state;

<u>(4)</u> [(3)] two professionals from the insurance industry who are authorized or licensed to do business in the state;

<u>(5)</u> [(4)] two persons who are not health care providers or financially interested in the field of health care or representatives of the insurance industry.

* Sec. 12. AS 21.88.050 is amended to read:

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

(1) in the form approved by the director, issue to al physicians, nurse midwives, and hospitals who are found to be accept able risks under standards developed under (5) of this subsection, an who pay the premiums for it, a contract or contracts indemnifyin physicians, nurse midwives, and hospitals and their employees who ar health care providers against loss by reason of liability for covere claims for an act or omission in the delivery of professional healt care in this state, and agreeing to tender on behalf of the physi cians, nurse midwives, and hospitals and their employees who ar health care providers a defense to a covered claim in a proceedin brought under AS 09.55.530 - 09.55.560; the limits of liability fo policies issued by the corporation shall be approved by the director the contract shall cover the defense against but need not indemnif liability for punitive damages arising from a covered claim; at th option of the corporation, if approved by the director, and for a additional premium the contract may cover claims against the physi cian, nurse midwife, or hospital that arise out of professional ser vices performed by the physician, nurse midwife, or hospital for an period before the contract is issued, except that coverage will not b provided for a claim already filed or of which the physician, nurs midwife, or hospital had or reasonably should have had notice at th time the retroactive insurance was purchased;

(2) charge a premium for the protection provided by th contracts issued by the corporation which shall be determined by th board of governors in accordance with AS 21.88.080 and subject to th 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)-(e), AS 21.18, AS 21.21, AS 21.24 and A 21.36; and shall be exempt from participation as a membe· insurer i the Alaska Insurance Guaranty Corporation;

(4) carry out the obligations of the contracts issued b the corporation by defending all covered claims made against insure health care providers and by paying all liabilities which are finall adjudicated against the insured health care provider or which may i the opinion of the corporation reasonably be expected to be finall adjudicated against the health ca·e provider to the extent of th contract obligation;

(5) establish standards for the acceptability of risks; i establishing these standards the corporation may exclude an applican for insurance based on individual risk selection factors, but may no exclude an applicant based only on the classification of the appli cant.

(b) The corporation may

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

(2) negotiate for and procure reinsurance from privat casualty insurers or reinsurers for any and all liability incurred b contracts issued by it;

(3) provide coverage to insureds for other hazards custom arily included in medical malpractice insurance policies when there i a finding by the director that this coverage is not available t insureds of the Medical Indemnity Corporation of Alaska in the privat

insurance market at a competitive price;

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

(5) negotiate and become a party to those contracts as ar 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 hospi tals;

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

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

(10) in a form approved by the director and for an addition al premium determined under AS 21.88.080, issue endorsements whic provide indemnity for claims not yet reported which arise out o professional services rendered during a period of continuous coverag under the originally issued contract, to physicians, nurse midwives and hospitals who pay the premium for it and who are terminating thei original covered claims contract with the corporation for a period o not less than one year;

(11) subject to approval by the director, extend coverage to a person, entity, or facility that renders health care services in state under the supervision of a physician.

* Sec. 13. AS 21.88.900 is amended by adding a new paragraph to read:

(17) "nurse midwife" means a registered professional nurse who is certified as an advanced nurse practitioner under AS 08.68.- 410(1) and authorized to practice as a nurse midwife under regulations adopted in accordance with AS 08.68.

* Sec. 14. AS 21.36.210(c), 21.36.230, and 21.36.300 are repealed.

* Sec. 15. This Act takes effect immediately in accordance with AS 01.10.070(c).

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March 11, 1986

Representative Mike Navarre
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Re: House Bill 522

Dear Representative Navarre:

I am writing to you on behalf of State Farm Insurance Company and Allstate Insurance Company to register our opposition to House Bill 522. Of all the legislation pending, this legislation, if enacted, would by far have the most significant adverse effect on the insurance industry. We want to explain the reasons why we oppose House Bill 522, as well as what we believe the practical effect of that legislation will be.

The Unfair Claims Settlement Practices Act, as it presently exists, was passed to <u>regulate</u> claims settlement practice. This legislation was introduced by Governor Hammond in 1976, and his intent in introducing this legislation is clear from the letter he sent which accompanied the bill:

> The bill gives the director of the division of insurance authority to investigate complaints and issue orders requiring persons to stop acts or practices in violation of the chapter. Once an order is issued, the bill provides that the director may also order a penalty of as much as $10,000.00 for each violation of the chapter and suspend or

> revoke the violator's license. In addition, the bill gives the director authority to seek injunctive relief to aid in the enforcement of the chapter.
>
> This bill is a strong, consumer-oriented measure which gives the director of the division of insurance more power to deal with unfair and deceptive practices than he presently has. The remedies in this bill provide broad relief to the insurance consumer through the insurance director.

Vol. I House Journal 1976, at 24. (Emphasis added).

As you can see from this letter, the legislation granted to the Director of the Division of Insurance broad authority to investigate and regulate claims settlement practices. It is significant that even this authority was based upon the premise that a single instance was not itself a violation, but a violation occurs only where the acts are committed with such frequency to indicate a practice.

House Bill 522 would change the focus of the original legislation, and would instead allow a claimant a private civil cause of action based upon a single violation of this act. Furthermore, House Bill 522 would allow a third-party claimant a private civil cause of action based upon a single violation of this act. The practical ramifications of the enactment of House Bill 522 are thus significant, for the Bill would create a private civil cause of action in cases where such a cause of action is not presently recognized.

If House Bill 522 is enacted, virtually every time there is disagreement about liability or damages, there will be the potential for a private civil cause of action based on an alleged violation of the Unfair Claims Settlement Practices Act. That this will occur is evident from a simple examination of the mechanics of the settlement process in a typical liability case. Every case that involves a settlement arises from an occurrence which allegedly caused injury to a third party. In every such case, two questions must be addressed before there can be a settlement: (1) Whether the insured was liable, and if so, the extent of his or her liability; and (2) The damages caused to the third party by the insured. In many cases, the questions of liability and damage are relatively clear, however in many others, those questions are not.

For example, Alaska has adopted judicially the concept of comparative negligence. This concept in essence provides that the party bringing the claim may be at fault as well, and that to the extent that party is at fault, he or she may not recover damages from the other side. The concept of comparative negligence requires a percentage allocation of responsibility to the party bringing the claim if that party was at fault. Many times, whether the defendant was at fault to begin with and if so, the nature and extent of the plaintiff's comparative fault are items which are legitimately and vigorously contested.

The same is true with respect to the question of damages. Since our legal system allows recovery for many types of damage that are not capable of being measured objectively, in many cases we see a significant and legitimate conflict as to the amount of damages the person is entitled to, even when liability is relatively clear. For example, one of the most difficult cases to resolve is a soft tissue neck case, and this is true regardless of whether liability is clear or not. There is no test that can be given to objectively determine the extent of the disability, and most such cases essentially turn on the credibility of the individual involved. This is also true in many other types of cases simply because there is no way to objectively measure certain types of damage such as pain and suffering.

If House Bill 522 is passed, an insurer would be exposed to a lawsuit virtually every single time a settlement offer made by a plaintiff is refused. Examples of such lawsuits in other states are numerous. For example, California has an Unfair Claims Settlement Practices Act which allows a private cause of action. In a recent case there the insurer refused a settlement offer made by the plaintiff, and the case proceeded to trial. Even though the jury ultimately awarded the plaintiff only one-fifth of that amount, the California Court still held the insurer could be found liable for failing to make proper efforts to settle the case.

It is virtually impossible to calculate the cost of such a system, for virtually every case that is settled would be settled under the shadow of an Unfair Claims Settlement Practices Act threat. Frankly, this is just about the worst thing that could be done by the legislature at a time when many insurance carriers have left the Alaska market, and the price of liability insurance has continued to rise. Instead of providing disincentives for insurers to do business in Alaska the legislature should provide incentives.

As our system presently exists, there are tremendous incentives for insurers to expeditiously resolve cases. First of all, prejudgment interest presently runs at a rate of 10.5% per annum, and this alone is a significant incentive for an insurer to expeditiously resolve a case. A second incentive for an insurer to resolve a case is simply the cost of litigation and the cost of claim handling. If an insurer can settle a case for a fair amount promptly, the insurer avoids the cost of having its claims adjustor continue to deal with that case, and furthermore avoids the significant legal fees that occur in the defense of virtually any personal injury lawsuit. A third incentive is the desire of both parties to avoid Rule 82 attorneys fees. Yet an additional incentive is the statutory offer of judgment that parties can file pursuant to AS 09.30.065. If a plaintiff files such an offer of judgment and this offer is not accepted, and the plaintiff then recovers a larger amount than the offer, the plaintiff recovers an additional 2% in interest, for a total of 12.5% per annum, from the time of the occurrence. These are significant incentives which are already present in our system which encourage both parties to expeditiously resolve claims, and frankly the system works well, for only a very small percentage of cases ultimately proceed to the courtroom.

If HB 522 is passed, the legislature in effect will create a new cause of action on the part of plaintiffs directly against insurance carriers. However, the legislature will be doing nothing to encourage plaintiffs to act more fairly and expeditiously in resolving disputes. It takes two parties to settle, and this legislation would govern the conduct of the insured party, but not the other party. If anything, the legislature should provide incentives for <u>all</u> parties, insured or not, to promptly and fairly resolve claims.

We know problems with claims have occurred in the past, and we suspect there will be occasional problems in the future, but disagreement is inherent in the adversarial system of justice. That system is now equally balanced, since neither a plaintiff nor an insured defendant may sue the other side for lack of good faith in negotiation. The passage of HB 522 would change that balance.

The cost and availability of insurance is one of the most significant problems facing the legislature this year. Passage of HB 522 will complicate rather than assist the resolution of this problem. We strongly feel that claims settlement practices should continue to be overseen by the Division of Insurance through the broad powers granted by the

present act. We thank you for the opportunity to comment on this issue.

Sincerely,

HUGHES THORSNESS GANTZ
POWELL & BRUNDIN

By: John G Frank for
Michael L. Lessmeier

MLL/mh
0419A

cc: Members of the House Labor and Commerce Committe

CORRECTION

Discard HB 522

and retain this corrected version.

Introduced: 1/29/86
Referred: Labor & Commerce
and Judiciary

IN THE HOUSE

BY SUND, KOPONEN AND GRUENBERG

HOUSE BILL NO. 522

IN THE LEGISLATURE OF THE STATE OF ALASKA

FOURTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to unfair insurance claims settlement practices; and providing for an effective date."

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

* Section 1. AS 21.36.125 is amended to read:

Sec. 21.36.125. UNFAIR CLAIM SETTLEMENT PRACTICES. A person may not commit or engage in with such frequency as to indicate a practice any of the following acts or practices:

(1) misrepresent a fact [FACTS] or policy provision [PROVISIONS] relating to coverage of an insurance policy;

(2) fail to acknowledge and act promptly on a communication [UPON COMMUNICATIONS] regarding a claim arising under an insurance policy;

(3) fail to adopt and implement reasonable standards for prompt investigation of claims;

(4) refuse to pay a claim without a reasonable investigation of all of the available information and an explanation of the basis for denial of the claim or for an offer of compromise settlement;

(5) fail to affirm or deny coverage of a claim [CLAIMS] within a reasonable time of the completion of a proof-of-loss statement [STATEMENTS];

(6) fail to attempt in good faith to make prompt and equitable settlement of a claim [CLAIMS] in which liability is reasonably clear;

(7) compel an insured or claimant [INSUREDS] to litigate for recovery of an amount [AMOUNTS] due under an insurance policy [POLICIES] by offering substantially less than the amount [AMOUNTS] ultimately recovered in an action [ACTIONS] brought by the insured or claimant [THOSE INSUREDS];

(8) attempt to make an unreasonably low settlement by reference to printed advertising matter accompanying or included in an application;

(9) attempt to settle a claim on the basis of an application that [WHICH] has been altered without the consent of the insured;

(10) make a claims payment without including a statement of the coverage under which the payment is made;

(11) make known to an insured or claimant [INSUREDS OR CLAIMANTS] a policy of appealing from an arbitration or court award [AWARDS] in favor of an insured or claimant [INSUREDS OR CLAIMANTS] for the purpose of compelling the insured or claimant [THEM] to accept a settlement or compromise [SETTLEMENTS OR COMPROMISES] less than the amount awarded [IN ARBITRATION];

(12) delay investigation or payment of a claim [CLAIMS] by requiring submission of unnecessary or substantially repetitive claims reports and proof-of-loss forms;

(13) fail to promptly settle a claim [CLAIMS] under one portion of a policy for the purpose of influencing a settlement [SETTLEMENTS] under another portion [OTHER PORTIONS] of the policy;

(14) fail to promptly provide a reasonable explanation of the basis in the insurance policy in relation to the facts or applicable law for denial of a claim or for the offer of a compromise settlement; or

(15) offer a form of settlement or pay a judgment in a [ANY]

manner prohibited by AS 21.89.030.

* Sec. 2. AS 21.36.125 is amended by adding new subsections to read:

(b) A claimant or insured who is injured by an act or practice listed in (a) of this section may bring an action in court to recover damages for the injury against the person who commits or engages in the act or practice; in this subsection one occurrence of an act or practice listed in (a) of this section is sufficient to give the claimant or insured the right to bring the action.

(c) In this section, "claimant" means a person who has been injured by an insured.

* Sec. 3. This Act takes effect immediately in accordance with AS 01.-10.070(c).

HB 522

An Act relating to unfair insurance claims settlement practices; and providing for an effective date.

SECTIONAL ANALYSIS
Prepared by Rep. John Sund's office.

Section 1, subsections 1-7, 11-13 and 15 amend AS 21.36.125 so that all prohibited insurance claim settlement practices are listed in the singular instead of the plural.

Section 1, subsection 7 states that a claimant cannot be forced into litigation by an insurer that is offering substantially less than the amount ultimately recovered from an insurance policy. The former language included only the insured in this section.

Section 2 adds a new subsection to AS 21.36.125 that permits an injured claimant or insured to sue an insurance company for acting in bad faith by committing any of the acts listed in section 1. One occurrence of any of the listed acts is enough to bring action.

"Claimant" is defined as a person who has been injured by an insured.

Section 3 makes the Act effective immediately.

HB 522

An Act relating to unfair insurance claims settlement practices; and providing for an effective date.

OVERVIEW
Prepared by Rep. John Sund's office.

Present law recognizes that insureds can be victims of insurers' unfair claims settlements practices, but does not include claimants as potential victims. Moreover, no timely legal recourse is offered for a claimant who is dealing with an insurance company that is acting in bad faith.

If a claimant wants to bring suit against an insurance company for not handling a claim properly, he or she must wait until the claim itself is settled -- in or out of court. That could be a matter of years. Meanwhile, the insurance company could continue acting in bad faith, delaying the settlement and causing further injury to the claimant.

The State Division of Insurance has a consumer protection office, but it takes complaints only from insureds, not claimants who have been injured by insureds. The office also will not handle cases that have been taken to court.

HB 522 would recognize claimants as potential victims of unfair practices.

HB 522 also specifies that a claimant or insured may take legal action against an insurer acting in bad faith. That would allow the legal action at any time, not just after the claim itself has been settled.

STATE OF ALASKA 1986 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: _____

REQUEST

Bill/Resolution No.: HB 522
Title: An Act relating to unfair claims settlement practices and providing for an effective date.
Sponsor: Sund
Requestor: Sund
Date of Request: February 14, 1986

FISCAL DETAIL

Agency Affected: Comm[illegible]e & Econ. Dev.
BRU: Division of Insurance
Components: Operations

EXPENDITURES / REVENUES : (Thousands of Dollars)

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES		75.6	75.6	75.6	75.6	75.6
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING		75.6	75.6	75.6	75.6	75.6
CAPITAL		-0-	-0-	-0-	-0-	-0-
REVENUE		-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of dollars)

GENERAL FUND		75.6	75.6	75.6	75.6	75.6
FEDERAL FUNDS						
OTHER						
TOTAL		75.6	75.6	75.6	75.6	75.6

POSITIONS:

FULL-TIME		2	2	2	2	2
PART-TIME						
TEMPORARY						

ANALYSIS: Attach a separate page if necessary.

This bill would extend our consumer specialist operations (in Anchorage) to claimants. Only the insured-insurer relationship (with two miror exceptions) is covered at present.

Prepared by: Paul Troeh, Deputy Director
Division: Insurance
Phone: 465-2515
Date: February 14, 1986

Approved by Commissioner: [signature]
Agency: Commerce and Economic Development
Date: February 14, 1986

Distribution (by Agency preparing fiscal note):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

10/25/85

3578W21486a

Position Title			No. of Positions	Range/Step	Barg. Unit	Gov.	Approv.	Disapp
Consumer Complaint – 2			16A	G				
Time Status	Staff Months	RP Number	Location	Election District		Leg.		
PFT	24		Anchorage					

Type of Expenditure		Amount
1	2	3
Salary	75.6	
Benefits		
Premium Pay		
Other		
Total Personal Services		75.6
Travel		-0-
Contractual		4.8
Commodities		1.0
Equipment		7.0
Other		
Total Cost		88.4

Receipt Code	Funding Source		
	Federal Receipts	1002	
	G. F. Match	1003	
	General Funds	1004	88.4
	I-A Receipts	1005	
	Program Receipts	1028	
	CIP Receipts	1061	
	Other		
			88.4

For B&M Use Only
Key Number _____

Justification

This bill will add "third party claimants" to those parties with access to our "consumer assistance" office. This will increase their work load by an estimated 50%, with cases increasing in complexity by 100%. It will also set up complex conflict of interest situations. A 100% staff increase at the intake officer level is required.

Request For New Position

Agency: Commerce and Economic Development

BRU: Insurance

Component: Operations

Page _____ of _____
Revised Date

FY 87

3578W21486a

AMERICAN COLLEGE OF NURSE-MIDWIVES

ALASKA CHAPTER, BOX 9416 Hiland Road, Eagle River, AK 99577

March 18, 1986

Representative Mike Navarre
Chairman, Labor and Commerce Committee
House of Representatives
Pouch V (MS 3100)
Juneau, Alaska 99811

Dear Representative Navarre:

This is a follow-up of my letter to your committee dated February 18th.

I understand that your committee has received a copy of draft legislation from Senator Fahrenkamp's office regarding an amendment to the statute which created the Medical Indemnity Corporation of Alaska (MICA). This amendment would give certified nurse-midwives the opportunity to acquire liability insurance as independent providers. The current statute only allows for coverage of nurse-midwives if they are an employee of a MICA covered physician.

Several nurse-midwives in Alaska work with physicians who have chosen to 'go bare'. These nurse-midwives will be out of business this summer and fall if alternative sources of coverage are not found. Certified nurse-midwives feel a moral and practical obligation to have liability insurance while providing care to childbearing women and infants.

In my previous letter, I mentioned that our national organization, the American College of Nurse-Midwives, is attempting to form its own insurance company. I recently received a copy of testimony presented to the United States Senate Committee on Commerce, Science and Transportation. (See enclosed). It is painfully obvious to me that while the ACNM has terrific intentions, they have several barriers to deal with and I do not envision any help for us on the national level this year.

Of the 29 certified nurse-midwives in Alaska, 14 are clinically active and will need continuing liability coverage by September 1. An amendment to the MICA statute is our best answer at present and we ask that you endorse passage of this amendment this session.

Over 1,000 Alaska infants arrived with our help last year and we want to continue to provide our valued service.

Please contact me for further information if needed. I look forward to your reply.

Sincerely, Marilyn Pierce-Bulger

Marilyn Pierce-Bulger, RN, MN, CNM
Chairman, Alaska Chapter, ACNM
wk 265-9245 hm 694-6076
Enclosures

Professional Liability Insurance for Certified Nurse-Midwives: Cost and Availability

United States Senate
Committee on Commerce, Science
and Transportation
March 4, 1986

Good morning. My name is Karen Ehrnman and I represent the American College of Nurse-Midwives (ACNM). I have been invited to share with you the difficulties which certified nurse-midwives have in obtaining professional liability insurance coverage.

This testimony will chronicle the extensive yet unsuccessful steps the College has taken on behalf of its members to obtain professional liability insurance. Additionally, I shall describe the obstacles resulting from the decision made by the College to study our options to assist nurse-midwives in establishing an independent mutual insurance company.

The impact of this situation on America's small business community is twofold: approximately one-third of our members are in private practice; another segment of our membership either owns or provides most of the health care in the nation's 140 birth centers. Until now, accredited birth centers have been a success story in the small business world. During the first three years of their operation, only eight to ten percent of these centers fail. By contrast, twelve centers have closed in 1985 -- largely as a result of an inability to obtain professional liability insurance.

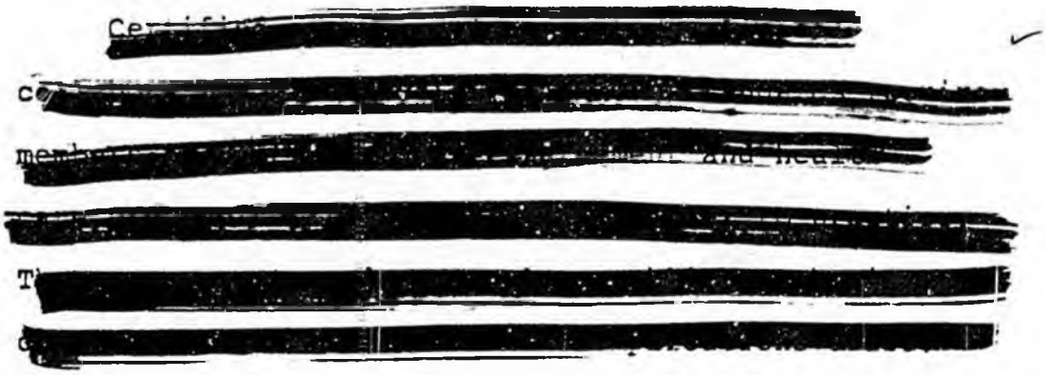
As a result of the unavailability of insurance from the private sector, the establishment of an insurance company providing professional liability coverage is the only option available to nurse-midwives. Without this company, nurse-midwives will be forced to end their services to mothers and children across the United States. Birth centers will close and private practitioners will seek other livelihoods.

Background on ACNM

The American College of Nurse-Midwives (ACNM) is the professional organization for nationally certified nurse-midwives (CNMs) in the United States. There are approximately 2,500 members of the ACNM, representing close to 85% of the profession. A full 95% of the members carry some type of professional liability insurance coverage.

Certified nurse-midwives are highly trained health professionals. Educated in both nursing and midwifery, they are specialists in maternal and child health care. They are licensed in all fifty states and provide care to the healthy woman before, during and after childbirth. They are experts in normal gynecologic and family planning care. Each member of the College has been officially certified through a national written examination.

The nurse-midwives work in a variety of settings -- such as private practices, university teaching hospitals, city hospitals, rural outreach centers, group health maintenance organizations, and health departments. Nurse-midwives deliver about three percent of the births in the United States. Approximately 75% of the births attended by certified nurse-midwives occur in hospitals, and another 15% occur in accredited birth centers.



ACNM also has reached a formal agreement outlining acceptable guidelines for working relationships with the American College of Obstetricians and Gynecologists.

Details of the Current Insurance Crisis

Since July, 1984, about 1400 CNMs have had professional liability insurance under a blanket ACNM policy written by the Mutual Fire, Marine and Inland Insurance Company. The remaining 1100 members of the College are

insured by their employers -- hospitals, health maintenance organizations, etc.

Mutual Fire notified ACNM in May, 1985 that the policy would not be renewed on July 1, 1985. ACNM's insurance was not renewed because of general conditions in the insurance industry -- the unavailability of reinsurance -- and not because of its members' professional performance. Suits have been filed against only six percent of all nurse-midwives -- a number not considered high among medical professionals. By comparison, 66.9 percent of obstetricians have been sued at least once according to the American College of Obstetricians and Gynecologists. In addition to the non-renewal of the blanket policy, over 300 individual certificates of insurance were cancelled this past July. These cancellations accounted for all of the individual certificates of insurance written after December 31, 1984; the remaining 1100 policies expired by December, 1985.

History of Insurance Coverage

Since the early 1970's, the American College of Nurse-Midwives has been able to obtain for its members a group policy that would pay up to one million dollars per claim. This one million dollar amount of insurance is the

amount which many hospitals require nurse-midwives to purchase in order to qualify for hospital privileges. It is this amount of insurance we want to make available to our members today.

Mutual Fire Marine and Inland Insurance was the third insurance carrier the ACNM has worked with in the past three years. The change in companies has been the result of three separate situations: 1) the inadequacy of the premium rate charged by one company; 2) the second company's withdrawal from the medical malpractice market; and 3) the nonrenewal of the reinsurance treaties for our most recent policy.

Steps Taken to Obtain New Insurance Policy

Early this year when ACNM received word that obtaining the master insurance policy might be difficult, we selected a "seasoned" broker with an excellent history of obtaining professional medical liability insurance. We believed that our broker understood what nurse-midwives are and that he would "market" us appropriately to the insurance industry. In search of a replacement for Mutual Fire we contacted 17 insurance companies in the United States. We were told that this represented most carriers in the U.S. who write professional liability

insurance. We were turned down by all of these companies.

After these 17 formal rejections from major insurance companies, ACNM made <u>personal</u> appeals to several insurance company presidents. We did this for several reasons: to better inform them about the relatively low risk that certified nurse-midwives would place upon their companies; to understand their reason for not insuring nurse-midwives; and to be certain that our request for insurance had been given a full evaluation. The response was still "no".

The American College of Nurse-Midwives again wrote to each of these 17 company presidents asking them to reexamine the decision. Many of these letters went unanswered. The message was clear -- no insurance.

Judging from the response we received from these insurance companies, we learned that many insurance companies had simply stopped writing malpractice policies. We also learned that within the speciality area of obstetrics, a crisis within a crisis was occuring. Insurers claim that the large premium increases which obstetricians and others are experiencing are necessary because of loss of profit resulting from unexpected

large numbers of claims and skyrocketing awards. What was never actually said -- but implied -- was that the premium levels necessary to cover CNMs would be beyond the reach of professionals making an annual salary of $25,000. Therefore, they offered no coverage at all.

But consumer groups, such as the National Insurance Consumer Organization (NICO), have accused the insurance industry of using misleading statistics in claiming a loss in 1985. Instead, NICO suggests the insurers have earned $6.6 billion. The ACNM is not an insurance analyst; we do know that nurse-midwives are not part of the malpractice insurance problem because of our very low rate of suits. We believe that it would have been possible for an insurance company to write a policy for nurse-midwives at a reasonable rate and based upon sound actuarial data. In fact, as I shall discuss later in this testimony, our plan is to do just that -- to establish an independent mutual insurance company which will underwrite CNMs at a reasonable rate.

State Level Initiatives

Our next course of action was to send nurse-midwives to talk with professional liability insurance companies in their states. The response was still "no". Nurse-

midwives talked to governors, state legislators, and state insurance commissioners. To date only one state out of fifty -- New Jersey -- has been able to offer insurance from a private carrier.

Still focusing at the state level, nurse-midwives investigated joint underwriting authority (JUA) and lobbied state legislators to extend joint underwriting authority to include nurse-midwives. We have been successful in implementing this in a number of states. However, for the most part, either the premiums for this coverage have been excessive or the amount of insurance offered has been less than required.

Other Considerations

As we evaluated the situation, nurse-midwives had little hope of obtaining affordable insurance from either the traditional insurers or the state JUAs. While these two options had been under consideration, the College's Board of Directors also commissioned a feasibility study on various options for self-insuring. Although this study indicated that it would be "feasible" for nurse-midwives to form an insurance company, the Board of Directors decided last summer that the insurance business

was beyond the limited resources of nurse-midwives. The Board directed the staff of ACNM to look into working with other groups to self-insure or to join another group's self-insure program. The response to these inquiries was also "no", although ACNM continues to communicate with the American Nurses' Association (ANA) about forming a company for all nurses.

Another option involved asking Congress to consider establishing a nurse-midwife sponsored insurance program. At that time we had interested a primary insurer in writing the first layer of insurance coverage. That company would have written the first $100,000 of coverage and the federal government would have provided the excess coverage from $100,000 to one million dollars. Even as we discussed this with members of Congress, however, the primary insurer had a change of heart.

The Re-examination of Self-Insure

Consideration of all of the options discussed up to this point utilized an enormous amount of resources. The process also strengthened the resolve of the leaders of the profession that searching for insurance could not become an annual event. Therefore the College's Board of

Directors sought a second opinion on the self-insure options. This second evaluation confirmed the earlier one. In December, 1985, the Board of Directors decided to further study this option.

Forming an Insurance Company

The emotion which accompanied the decision to study helping certified nurse-midwives form an independent mutual insurance company was short-lived. Even after hiring consultants and attorneys, the road blocks before us are enormous.

Disregarding the very difficult financial problems, the following are some of the legal and technical complications which hinder the establishment of a company.

The Claims-Made Policy

One technical problem is the type of policy currently being written -- a claims-made policy. In the past professionals have been able to purchase occurrence policies. There is a very important distinction between these two types of policies -- a distinction which is critical to nurse-midwives as well as physicians.

An occurrence policy insures for all claims arising out of events which occurred during the covered

period regardless of when the claim is filed. A claims-made policy insures only those claims which are filed during the policy year no matter when the event occurred. Does it matter? Yes.

For example, under an occurrence policy issued in February 1986 - February 1987, the nurse-midwife would be covered for any claim related to a delivery during this calendar year, even if the family did not file the claim until the child entered elementary school or even college. A claims-made policy, on the other hand, would only cover those claims filed during the February 86 - February 87 calendar year. To be covered for claims filed after this time period the professional must purchase "tail coverage". What further complicates all of this is that in this insurance market it is impossible to buy a "tail" for 21 years -- the coverage that nurse-midwives and obstetricians need. In addition, insurance companies will not quote a price on a "tail" until it is needed, but we have been told it is likely to be two to three times the cost of a one year premium -- and can be more. We have been told by the insurance industry that primary insurers are switching to claims-made policies be-

cause reinsurers will not write occurrence policies. Reinsurers argue that it is easier to anticipate costs with a claims-made policy.

Regulatory Roadblocks in Forming an Insurance Company

Simply stated, we have been informed by our legal counsel that under the insurance laws of virtually all of the states, a new insurance company could not write insurance unless it became licensed in each of these states. This is a costly and time-consuming process that takes several years -- time we simply do not have. Also, the capital requirements of a few of the states exceed even our collective resources. Our legal counsel has reviewed the situation to see if exemptions from this licensing process exist, but none is available to us due to the number, size and geographic spread of our membership.

In 1981, Congress realized that this almost identical problem existed for small businessmen affected by the lack of product liability insurance, when it enacted the Risk Retention Act. This Act allowed groups of business to form risk retention groups to collectively insure the product liability risks of the members of the group without first becoming licensed as an insurer in any

jurisdiction other than that of the domicile of the risk retention group itself. In 1985, Congress again realized that a similar problem existed when the House and the Senate passed an almost identical bill (which is part of the Super Fund legislation now before Congress) to provide for risk retention groups for environmental impairment liability insurance.

We ask you to provide us with the same type of legislation to permit formation of [redacted] for professional liability insurance for nurse-midwives and birthing centers.

Nurse-midwives Current Status: Temporary Insurance Coverage

In considering practicing without insurance, most CNMs, as well as most physicians, feel both a moral and practical obligation to protect their patients and themselves from any unintentional human error. In addition, many CNMs must carry professional liability insurance to retain their employment and/or hospital privileges.

In an attempt to keep practicing, most of our members purchased insurance during this past year from one of two

nursing groups whose policies did not include an exclusion of nurse-midwives. These organizations are the American Nurses' Association (ANA) and the Nurses' Association of the American College of Obstetricians and Gynecologists (NAACOG). The insurers of both of the groups have subsequently written into the policies exclusions of nurse-midwives. An informal survey of our membership indicates that this temporary coverage will begin to run out this spring and by next December no CNMs will have insurance if not provided by their employers or state JUA.

Requested Actions

I am certain you will agree with us that the formation of the insurance company over the next few months is critical. Congress can help. We urge Congress to: amend the 1981 Risk Retention Act; address the problem of the unavailability of reinsurance; and establish the availability of occurrence-type policies.

1) Amend the 1981 Risk Retention Act:

An expansion of this law to allow groups such as ours to establish an insurance company is essential. The idea we seek to implement is after meeting the requirements in a selected state for establishing the company, the company would be able to write insurance in all fifty states. This is the

only way that we will be able to offer insurance to our members in all fifty states.

2) Address the problem of reinsurance unavailability:

Our problem began when Mutual Fire's reinsurance treaties were not renewed. Since then we have heard many insurers state that their capacity to write insurance is limited by the unavailability of reinsurance. A new company also cannot get reinsurance and this substantially increases both short and long term financial risks.

In this regard, the American College of Nurse-Midwives urges you to make reinsurance available. This could be done by legislating the plan for federally-based reinsurance which has been drafted by the National Insurance Consumers Organization, investigating U.S. business practices and legislating changes to encourage the establishment of U.S. owned reinsurance companies.

3) Make occurrence policies available.

Nurse-midwives cannot purchase an occurrence policy. Additionally, in studying the possible formation of a new company, we have been advised that

this company would also have to write a claims-made policy. The reason is that reinsurers will only reinsure the claim-made type policy. This situation must be changed.

Lastly, we need this assistance quickly. Although some private practices and birthing centers have already gone out of business, by spring the vast majority of these small businesses will be vulnerable. Thank you for your support and interest in this problem.

LAWYERS' COMMITTEE
FOR CIVIL RIGHTS UNDER LAW

SUITE 400 • 1400 EYE STREET, NORTHWEST • WASHINGTON, D.C. 20005 • PHONE (202) 371-1212

CABLE ADDRESS: LAWCIV, WASHINGTON, D.C.

August, 1984

MEMORANDUM

RE: The Constitutionality of State and Local Divestiture Legislation

FROM: The Lawyers' Committee for Civil Rights Under Law*

In the last few years a number of state and local governments have acted to withdraw investments of pension and other governmental funds from firms doing business in South Africa. This "divestiture" by state and local governments of funds invested in firms doing business in South Africa has been criticized as unconstitutional in the halls of Congress and elsewhere. State divestment, and in particular state divestiture legislation, these critics contend, both violates the foreign commerce clause of Article I of the Constitution and intrudes

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* The Lawyers' Committee gratefully acknowledges the assistance of Mark P. Gergen, an associate at the law firm of Arnold & Porter, in the preparation of this memorandum. Please direct all inquiries regarding this document to Gay J. McDougall, Director, Southern Africa Project, Lawyers' Committee for Civil Rights Under Law.

upon the impliedly exclusive authority of the federal government to conduct foreign relations.[1]

The charge that state and local divestiture legislation is unconstitutional is misguided and without basis in either constitutional principle or judicial precedent. Divestiture is grounded on the undisputed authority of a state to manage its own finances and to determine what activities it will support. State divestiture legislation does not violate the Commerce Clause, for that clause is simply not concerned with this type of state proprietary decision. Nor does such legislation impermissibly intrude upon the federal foreign relations power. State divestiture legislation violates no statute, treaty or executive agreement of the United States, and so transgresses none of the grounds upon which state action has traditionally been deemed violative of national foreign policy. Further, as a form of proprietary action state divestiture is not so disruptive

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[1] Larry M. Eig (Legislative Attorney, American Law Div., Congressional Research Service). Analysis of Whether the District of Columbia South Africa Investment Act (D.C. Act 5-76) Violates the Commerce Clause of the Constitution and the Exclusive Federal Power To Conduct Foreign Relations (Jan. 31, 1984) ("CRS Memorandum"); Note, Constitutionality of the No Discrimination Clause Regulating University of Wisconsin Investments, 1978 Wis. L. Rev. 1059. See also Letter of Philip M. Crane to Members of the House of Representatives, Jan. 24, 1984.

of foreign relations to warrant its prohibition on the basis of some presumed constitutional principle prohibiting state action which impairs this nation's foreign relations.

I. The Divestiture Movement.

In recent years opponents of apartheid in this country have sought to compel American firms to cease doing business with or in South Africa. The movement has taken a variety of forms, including shareholder corporate governance resolutions, consumer boycotts of South African products, and, most prominently, threats by governments, labor unions, and other prominent institutions to withdraw funds invested in firms or banks doing business in South Africa. The divestiture movement is important, for American businesses play a significant role in South Africa, and those businesses depend upon investments from public and private pension funds.[2]

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[2] Currently, over 5,000 American companies do business in South Africa, and total United States investment in that country is over $14 billion. American corporations play a significant role in such important sectors of the South African economy as petroleum, automobiles, and the computer industry. See Davis, Cason, and Hovey, Economic Disengagement and South Africa: the Effectiveness and Feasibility of Implementing Sanctions and Divestment, 15 L. & Pol. Int. Bus. 529, 545-49 (1983).

[Footnote continued on following page]

The divestiture cudgel has been picked up by private organizations as diverse as Yale University, the National Council of Churches, and trade union pension funds. This private action poses few legal difficulties, even though it has been argued that divestment by a trustee of a pension fund or a charitable trust might violate the fiduciary duty to the beneficiaries of the fund or trust to maximize investment return.[1] More problematic is divestiture by state and municipal governments, for that raises Constitutional issues not implicated by private action concerning the power of state and local governments to play a role in shaping this nation's commercial and political relations with South Africa.

States which have divested in some fashion include

[Footnote 2 continued from preceding page]
It has been reported that public and private pension funds own one-quarter of all publicly traded stock and control more than two-fifths of all debt capital in this country. Id. Indeed, General Motors reports that 10% of its total debt is held by public funds, such as pension systems and state cash accounts. Wall Street Journal, April 18, 1984, at 33, col. 4.

[1] Note Socially Responsible Investment of Public Pension Funds: The South Africa Issue and State Law, 10 N.Y.U. Rev. L. & Soc. Ch. 408 (1980-81), responds to this criticism of private divestiture.

Connecticut,[4] Massachusetts,[5] Michigan,[6] Nebraska,[7] and Wisconsin.[8] Cities which have acted include the District of Columbia,[9] Philadelphia,[10] San Francisco, and Wilmington. Currently, similar initiatives are pending before numerous other state legislatures and city councils.[11]

The decision to divest has been made by states in a variety of fashions. In Massachusetts, for example, divestiture was in the first instance done informally

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[4] CONN. GEN. STAT. ANN. § 3-13f.

[5] MASS. GEN. LAWS ANN. ch. 32, § 23. See also 1979 MASS. ACTS ch. 393, item 0612-1500.

[6] MICH. COMP. LAWS §§ 25.145(5); 37.2402(1)(f).

[7] LR43, Neb. 86th Leg., 2d Sess. (Mar. 31, 1980). It has been reported that Nebraska recently enacted formal legislation imposing some restrictions on investments of public pension funds in firms doing business in South Africa. Wall Street Journal, April 18, 1984, at 33, col. 4.

[8] WIS. STAT. ANN. § 36.29(1), which prohibits University of Wisconsin investments in firms which discriminate on the basis of race, has been interpreted by the Wisconsin Attorney General to prohibit investment in companies that do substantial business in South Africa.

[9] D.C. Law 5-50 (1984).

[10] Bill 1060-A (June 17, 1982).

[11] It has been reported that divestiture bills are now pending in 26 states -- including New York and California, the two most populous states -- and 20 cities. Wall Street Journal, April 18, 1984, at 33, col. 4; Christian Science Monitor, March. 2, 1984, at 3.

by a decision of the Massachusetts State Treasurer to no longer place new investments in firms doing business with South Africa.[12] Later, the Massachusetts legislature formally acted to require divestment by state owned employee pension funds.[13] Other jurisdictions which have enacted legislation specifically requiring divestiture include Michigan, Connecticut and the District of Columbia. In Wisconsin, on the other hand, divestiture was ordered by the State Attorney General who interpreted a statute generally prohibiting the investment of state funds in firms which practiced race discrimination as prohibiting the investment of state funds in firms doing business in South Africa.[14] And, in Nebraska the state's policy of divestiture was first announced by an informal legislative resolution.

The fashion by which states divest is as varied as the process by which the decision to divest is reached. Connecticut, for one, merely requires that as a condition to the receipt of investments of state funds a company doing business in South Africa must agree to adhere to the Sullivan Principles and not to give succor to

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[12] N.Y.U. Note, supra, n.3 at 414-15, n.66.

[13] MASS. GEN. LAWS ANN. ch. 32, § 23.

[14] 67 Wis. Op. Att'y Gen. 20 (1978).

the South African armed forces or police.[15] Most other jurisdictions have required complete divestment and not merely adherence to the Sullivan Principles. So, Michigan prohibits investments in "organizations operating in South Africa."[16] Casting its net somewhat wider, the District of Columbia prohibits investment in any company or financial institution "doing business in or with the Republic of South Africa or Namibia."[17]

Divestiture legislation need not even identify South Africa as its subject. The Wisconsin experience illustrates how a general legislative mandate that funds not be invested in firms that practice race discrimination could be applied to bar investments in firms operating in South Africa, which of necessity must follow discriminatory employment practices. Similar legislation has been proposed in Oregon either to prohibit investments of state funds in firms which practice or condone discrimination or, alternatively, to prohibit investment

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[15] CONN. GEN. STAT. ANN. § 3-13f. The Sullivan Principles require that a corporation doing business in South Africa desegregate the workplace, treat workers equally, provide training for blacks, and seek to improve the quality of workers' lives. See Davis, et al., supra, n.2 at 550-53.

[16] Mich. Comp. Law § 37.2501(1)(f). The Michigan statute also requires divestment from organizations operating in the Soviet Union. Id. 37.2501(1)(g).

[17] D.C. Act 5-76, § 2.

'in any firm which conducts substantial business operations in any country whose laws on their face require invidious discrimination on the basis of race, color or national origin."[11] The Michigan statute is comparable in that its stated purpose is to not "encourage or condone legally required discrimination against an individual on the basis of race or color," however the law goes on to specifically prohibit investments in firms operating in South Africa.[12]

The diverse forms of divestiture complicate the analysis of the movement's constitutionality. The arguments which may be made against "purer" forms of divestiture legislation -- such as the Michigan or the District of Columbia laws which simply prohibit investments in firms doing business in South Africa -- are considerably muted when directed at other forms of action. So, divestment seems less an intrusion by a state into foreign relations where it is the consequence, as it was in Wisconsin, of the implementation by a state of a general edict not to support firms which practice discrimination. At the same time, it is impractical for federal courts to oversee state investment

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[11] Senate bill 957, 1979 regular session.

[12] MICH. COMP. LAW § 37.2501(f).

activities to ensure that divestiture is not accomplished informally, as it was first done, for example, in Massachusetts. The regulation of such informal divestment would require close scrutiny of the day-to-day investment decisions made by the fund administrator and a critique of his estimate of the comparative value of various investment strategies to determine if his decisions were made for some "invidious" reason. This memorandum does not address these and similar issues raised by the more subtle forms of state divestiture. Rather, it focuses on the most straightforward issue, the constitutionality of state legislation which explicitly prohibits the investment of state funds in firms doing business in or with South Africa.

II. The Constitutional Basis for Divestiture.

That the Constitution endows a state with authority to determine how its own funds will be invested is indisputable. The Supreme Court has recognized that an essential element of state sovereignty is the control by a state over its own finances.[20] Further, the Court has recognized that the Constitution leaves a state with considerable discretion to determine which activities

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[20] National League of Cities v. Usery, 426 U.S. 833, 855 (1976).

it will subsidize.[11] Divestiture implicates both of these functions. On one hand, divestiture involves a decision by the state as to how best to administer its own funds. At the same time, divestiture represents an effort by the state to invest its funds in a socially responsible manner so that it does not support the South African system of apartheid.

Critics of divestiture argue that no legitimate state interest is served by divestiture.[12] However, they ignore the primary justification of divestiture:

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[11] The issue of the constitutional restraints on subsidy choices by a state has arisen most starkly in the abortion funding cases, where the Court has held that a state may refuse to fund abortions while funding childbirth. Harris v. McRae, 448 U.S. 297 (1980); Maher v. Roe, 432 U.S. 464 (1977). In Maher v. Roe, the Court explained:

> There is a basic difference between direct state interference with a protected activity and state encouragement of an alternative activity consistent with legislative policy. Constitutional concerns are greatest when the State attempts to impose its will by force of law; the State's power to encourage actions deemed to be in the public interest is necessarily far broader. 432 U.S. at 475-76, citing Buckley v. Valeo, 424 U.S. 1 (1976).

[12] CRS Memorandum, supra, n.1 at 16, 34; Wisconsin Note, supra, n.1 at 1063-65.

that is, the interest of a state as an financier to ensure that its investments are made in a socially responsible manner. The clarion call of the divestiture movement, in both public and private quarters, has been the principle that investor is morally responsible for the use to which his funds are put. No constitutional principle bars a state from so noticing the moral consequences of its actions.

III. The Foreign Commerce Clause.

Opponents of divestiture legislation argue that it violates the Foreign Commerce Clause of Article I of the Constitution. The clause, which empowers Congress "To regulate Commerce with foreign Nations, and among the several States," has long been interpreted by the Supreme Court to prohibit, by implication, overly burdensome state regulation of foreign or interstate commerce or "parochial" state regulation which discriminates against foreign or interstate commerce.[23] Critics of state divestment urge that it impermissibly restricts commerce with South Africa, in violation of the Commerce Clause, and that it furthers no corresponding

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[23] The leading case of the modern era enforcing the dormant commerce clause is Southern Pacific Co. v. Arizona, 325 U.S. 761 (1945).

state interest which might justify the action.[24]

The argument that divestiture legislation violates the Commerce Clause is of little weight. The Commerce Clause simply does not apply to this type of state proprietary decision. In a bevy of recent decisions the Supreme Court has held that the Commerce Clause restricts only the power of a state to regulate or tax commerce, and that the clause imposes no restrictions on the right of a state to choose who it will do business with as a buyer or a seller in the free market.[25] Divestiture, of course, does not involve the regulation or taxation of commerce. Rather, it simply involves the refusal by a state or local government to deal with companies or banks which support the South African system of apartheid.

Hughes v. Alexandria Scrap Corp.[26] is the first case to consider whether the Commerce Clause governs state action of a proprietary nature. At issue in Hughes was the constitutionality of a Maryland program providing

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[24] CRS Memorandum, supra, n.1 at 9-25; Wisconsin Note, supra, n.1 at 1063-66.

[25] White v. Massachusetts Council of Construction Employers, 75 L. Ed. 2d 1 (1983); Reeves, Inc. v. Stake, 447 U.S. 429 (1980); Hughes v. Alexandria Scrap Corp., 426 U.S. 794 (1976).

[26] 426 U.S. 794 (1976).

bounties to junkyards for scrapped automobiles which required out-of-state junkyards to provide more thorough documentation of ownership of the vehicle on which the bounty was claimed than was required of Maryland junkyards. A Virginia junkyard challenged the disparate documentation requirements as discriminatory against interstate commerce, invoking precedent declaring state discrimination against interstate commerce to be impermissible per se under the Commerce Clause.[27] The Court rejected that argument, reasoning that the purpose of the Commerce Clause was to prevent states from erecting barriers to interstate commerce by taxation or regulation, and concluding that the clause was not concerned where a state participated in the market to favor its own citizens.[28]

The issue of Commerce Clause limitations on state proprietary action was next raised in Reeves, Inc. v. Stake.[29] At issue in Reeves was a decision by South Dakota to confine the sale of cement from a state owned cement plant to state residents. As in Hughes v. Alexandria Scrap, the plaintiff argued that the Commerce

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[27] Pike v. Bruce Church, Inc., 397 U.S. 137, 142 (1970).

[28] 426 U.S. at 807-08.

[29] 447 U.S. 429 (1980).

Clause prohibited such discrimination by a state against interstate commerce. The Court held otherwise, concluding that "[t]here is no indication of a constitutional plan to limit the ability of the States themselves to operate freely in the free market."[10] The Court reasoned that the freedom of the state to restrict sales as it wished was counseled by "the long recognized right of trader or manufacturer, engaged in an entirely private business, freely to exercise his own independent discretion as to parties with whom he will deal."[11]

The issue of state proprietary action was addressed by the Court most recently in White v. Massachusetts Council of Construction Employers, 75 L. Ed. 2d 1 (1983). There the Supreme Court rejected a Commerce Clause challenge to a Boston requirement that half the workforce in municipally funded construction projects be residents of Boston -- again, on the ground that the Commerce Clause does not reach proprietary activity.

In light of this authority, the argument that divestiture might in some way violate the Commerce Clause is mystifying. Critics of divestiture have suggested

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[10] Id. at 437.

[11] Id. at 438-39, quoting United States v. Colgate & Co., 250 U.S. 300, 307 (1919).

that this precedent is inapposite to the issue of the constitutionality of divestiture legislation since Alexandria Scrap and its progeny concerned interstate, and not foreign commerce.[12] There is, however, no basis for restricting the principle that states may deal with whom they please in the marketplace to market decisions of a purely domestic character. The only court to face the question has held that the proprietary action doctrine applies to foreign commerce as well as domestic. At issue in K.S.B. Technical Sales Corp. v. North Jersey Dist. Water Supply Co.,[13] was the constitutionality of New Jersey's "Buy American" statute, which provided a preference for United States-produced goods in state procurement. The New Jersey Supreme Court upheld the law against a Commerce Clause challenge, reasoning that Alexandria Scrap immunized a state's proprietary conduct from scrutiny under that clause. In reaching that result the court specifically rejected the argument that proprietary activities were of a significantly different

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[12] CRS Memorandum, supra, n.1, at 21. In Reeves the Court remarked that "[w]e have no occasion to explore the limits imposed on state proprietary actions by the 'foreign commerce' Clause," and observed that "Commerce Clause may well be more rigorous when a restraint of foreign commerce is alleged." 447 U.S. at 438 n.9.

[13] 75 N.J. 272, 381 A.2d 774 (1977), appeal dismissed, 435 U.S. 982 (1978).

tenor when they involved foreign commerce.[14]

The CRS Memorandum relies upon Japan Line Ltd. v. County of Los Angeles[15] as authority for restricting the proprietary action doctrine to the domestic context. In that case the Supreme Court held unconstitutional a California ad valorem tax imposed on shipping containers temporarily within the state which were used exclusively in foreign commerce. The Court posited that the tax might withstand scrutiny if imposed on instrumentalities of interstate commerce, but concluded that "more extensive constitutional inquiry is required" where foreign commerce was at stake.[16] The Court identified two factors present in the international context not present in the domestic context which compelled invalidation of the California tax. First, the Court observed that the danger of multiple taxation was greater in the international context since it had no power to allocate authority to tax among the competing jurisdictions, as it does when the dispute

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[14] 381 A.2d at 738. A decision by a lower court in California striking down that State's "Buy American" statute, Bethlehem Steel Corp. v. Board of Commissioners, 276 Cal. App. 2d 221, 80 Cal. Rptr. 800 (1969), predates Alexandria Scrap.

[15] 441 U.S. 434 (1979).

[16] Id. at 445-46.

over power to tax is between states.[37] Second, the Court reasoned that the tax undermined a significant national interest in the uniformity of treatment of cargo containers, an interest the Court found evidenced by federal statutes and treaties.[38]

Japan Lines does not, however, suggest that the "foreign commerce" clause might restrict the freedom of a state to deal with whom it pleases in the international marketplace.[39] The decision involved regulatory rather than proprietary, state action. Proprietary state action simply does not implicate one concern identified in Japan Lines -- the risk that states might subject persons to multiple or inconsistent regulatory burdens. Moreover, as is explained fully below, divestiture does not run afoul of some pressing national interest in uniformity. Unlike the tax at issue in Japan Lines, divestiture violates no plainly expressed policy of the United States with respect to foreign

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[37] Id. at 446-48.

[38] Id. at 448, 452-53.

[39] The principles enunciated in Japan Lines are far from absolute. In a case decided four years later, Container Corp. v. Franchise Tax Board, 77 L. Ed. 2d 545 (1983), the Court upheld a state unitary tax imposed on subsidiaries of foreign corporations, even though the unitary tax created some risk of double taxation and was disturbing to foreign nations.

commerce.[40]

Critics of state divestiture further argue that such legislation violates the Commerce Clause because it advances no legitimate local interest.[41] However, the Supreme Court did not inquire into whether the challenged action served some legitimate interest in Alexandria Scrap and the other proprietary action cases. Instead, the Court simply held state proprietary action to be immune from scrutiny under the Commerce Clause. Thus, the nature of the interest served by divestiture legislation is seemingly irrelevant to the question of its constitutionality under the proprietary action doctrine. Moreover, divestiture does serve a legitimate state interest; that is, the interest by a state in the responsible investment of its funds. While this interest is largely moral in character, that does not diminish its legitimacy under constitutional doctrine.

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[40] In Japan Lines the Court emphasized that the tax was inconsistent with the policy of the United States, expressed both in treaty and statute, to eliminate impediments to the use of shipping containers in commerce. 451 U.S. at 452-53. In Container Corp., in comparison, where the tax at issue violated no explicit policy of the national government, the Court concluded that the tax was constitutional even though foreign countries were strongly opposed to it. 77 L. Ed. 2d at 571-73.

[41] CRS Memorandum, supra, n.1 at 18; Wisconsin Note, supra, n.1 at 1063-66. Traditional Commerce Clause analysis requires that state regulation of interstate commerce serve some local interest that outweighs the burden cast by the regulation on interstate commerce. See Pike v. Bruce Church, Inc., 397 U.S. 137 (1970).

IV. The Foreign Affairs Power.

The second objection raised to state divestiture legislation is that such action by a state impermissibly intrudes upon the "exclusive" authority of the federal government to conduct this nation's foreign relations. Critics of divestiture legislation observe that the effect and apparent purpose of such legislation is to disappoint or injure the South African government. This, the critics of divestiture legislation contend, states may not do because the Constitution implicitly forbids them from so interfering in the foreign relations of the national government.[42]

It is important to keep in mind the limited ground upon which state divestiture is claimed to be objectionable. It is not argued that divestiture violates any of the few Constitutional provisions specifically defining the proper role of states in matters of "foreign relations."[43] It is plain that state divestiture does

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[42] Wisconsin Note, supra, n.1 at 1066-70; CRS Memorandum, supra, n.1 at 25-33. See also Letter of Philip M. Crane to Members of the House of Representatives, Jan. 24, 1984.

[43] It has been said that "where foreign relations are concerned the Constitution seems a strange, laconic document: although it explicitly lodges important foreign affairs powers in one branch or another of the federal government, and denies important powers to the States, many others are not mentioned." L. Henkin, Foreign Affairs and the Constitution (1972) 16.

not violate any express constitutional mandate. In the area of foreign relations the only powers specifically denied to states by the Constitution are the power to enter into treaties or agreements with foreign states, to engage in war, and to tax imports and exports.[**] Divestiture runs afoul of none of these prohibitions.

Nor is it claimed that divestiture is inconsistent with any statute, treaty or executive agreement of the United States. Rather, state divestiture legislation is consistent in principle with the national policy toward South Africa and apartheid.[***] The absence of any inconsistency betweeen state divestiture legislation

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[**] Article I, section 10 of the Constitution provides that "No state shall enter into any Treaty, Alliance, or Confederation [or] grant Letters of Marque and Reprisal"; it requires that Congress consent to state "Imposts or Duties on Imports or Exports"; and, it mandates that states not "enter into any Agreement or Compact . . . with a foreign Power, or engage in war" without the consent of Congress.

[***] The official position of the United States government is that it is opposed to apartheid. Thus, the United States has imposed a ban on the export by American firms to South Africa of arms, military equipment, and any other goods which might be used by the military or police. See Mehlman, Milch, and Toumanoff, United States Restrictions on Exports to South Africa, 73 Am. J. Comp. L. 581 (1979). And, Congress is now considering legislation to impose even further restrictions on trading by American firms with South Africa. H.R. 3231, 98th Cong., 2d Sess., which was passed by voice vote in the House last fall, would amend the Export Administration Act of 1978 to ban all new investment in South Africa by United States firms and banks.

and federal law is of crucial importance, for in almost every instance where the Supreme Court has held unconstitutional an action by a state because it was overly intrusive on the federal foreign relations power, that action was found to violate some specific provision of a federal statute, treaty, or executive agreement.[46] The Supreme Court has ruled that in the absence of such authority federal courts are properly reluctant to presume any inconsistency between an action by a state and federal foreign policy requiring invalidation of the action.[47]

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[46] So, in Hines v. Davidowitz, 312 U.S. 52 (1941), the Court struck down a state alien registration system because it conflicted with the federal system. The Court expressly declined to address the argument that ". . . the federal power in this field, whether exercised or unexercised, is exclusive." Id. at 62. Similarly, two other cases which are prominently cited as support for the proposition that the federal foreign relations power is exclusive -- United States v. Pink, 315 U.S. 203 (1942), and United States v. Belmont, 301 U.S. 324 (1937) -- involved the refusal by a state to honor the claim of the Soviet Union to the domestic assets of a nationalized Russian company in contravention of an executive agreement that the Soviet claim would be honored by this nation.

[47] Recently, in Container Corp. v. Franchise Tax Board, 77 L. Ed. 2d 545 (1983), the Supreme Court stated that it would not strike down a state tax on multi-national enterprises, despite the tax's impact on the foreign relations of the United States, where the tax violated no act of Congress and was not opposed by the Justice Department as amicus curiae. The Court concluded that, while not dispositive, the absence of such authority "does suggest that the foreign policy of the United States -- whose nuances we must emphasize again, are much more the province of the Executive Branch and Congress than of this Court -- is not seriously threatened" by the tax. Id. at 573.

Because of the absence of any contrary constitutional provision, federal statute, or treaty, the argument that state divestiture in someway intrudes upon the foreign relation power of the federal government rests on the extreme premise that states are simply prohibited by the Constitution from acting in a manner which might irritate a foreign government. There is little authority to support the argument that the Constitution so inhibits the power of states. Rather, by precedent and historical practice, it is plain that states are free to undertake actions done in a traditional capacity even though their action injures or offends a foreign government. Thus, it has been held that a state may adopt reciprocal legislation conditioning the right of an alien to inherit property on the grant of a similar right to United States citizens by the alien's country.[**] A State court may examine the fairness of judicial process of a foreign country to determine if it will enforce a judgment rendered there, and in choice of law a state court may refuse to apply foreign laws it finds distasteful.[**] And, state legislatures

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[**] Clark v. Allen, 331 U.S. 503 (1947); Gorun v. Fall, 287 F. Supp. 725 (D. Mont. 1968), affirmed, 393 U.S. 398 (1969).

[**] See, e.g., J. Zeevi & Sons, Ltd. v. Grindlays Bank, Ltd., 37 N.Y.2d 220, 371 N.Y.S.2d 892, 333 N.E.2d 168, cert. denied, 423 U.S. 866 (1975) (confiscation of funds

[Footnote continued on following page]

and state officials have traditionally used their office to criticize the actions of foreign governments. No one has ever suggested that this practice, which has long been a part of the process by which the United States' foreign policy is shaped democratically, might potentially be constitutionally infirm.[50]

In only one case has the Supreme Court held an action by a state forbidden on the basis of its impact on the foreign relations of the United States where the action did not also violate some federal statute or treaty. That case is Zschernig v. Miller,[51] a 1968

[Footnote 49 continued from preceding page]
by Uganda not recognized as a defense in action for reimbursement); Uniform Foreign Money-Judgments Recognition Act Sec. 4(a)(1) (foreign money judgment will not be recognized if it "was rendered under a system which does not provide impartial tribunals or procedures compatible with the requirements of due process of law.") The Supreme Court has consistently recognized that a state need not enforce a foreign judgment or apply a foreign law in its courts "where to do so would be repugnant to good morals." Bond v. Hume, 243 U.S. 15, 21 (1917). See also United States v. Pink, 315 U.S. 203, 231 (1942) (noting "the power of a state to refuse enforcement of rights based on foreign law which runs counter to the public policy of the forum" when Federal statute or treaty does not dictate otherwise.)

[50] Professor Henkin observes that the State Department has little "influence to prevent embarrassing 'sense resolutions' of state legislatures on foreign issues." Henkin, supra, n.43 at 247.

[51] 389 U.S. 429 (1968).

decision.[52] In Zschernig, the Supreme Court held unconstitutional an Oregon law which escheated alien inheritances where the alien's homeland practiced confiscation of private property, did not permit United States citizens to remove inheritances to the United States, or did not grant United States citizens a reciprocal right of inheritance. The Court held the Oregon law was "an intrusion by the State into the field of foreign affairs which the Constitution entrusts to the President and the Congress."[53] In reaching that result, the Court focused on several aspects of the Oregon law it thought particularly damaging to this nation's foreign relations. Most notably, the Court stressed repeatedly that it thought it improper for state court judges to closely examine and criticize the practices of foreign governments.[54] In addition, the Court remarked upon the notoriety of such inheritance statutes[55] and observed that in a few cases the administration of such laws had provoked protests from

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[52] Louis Henkin has said that "[u]ntil 1968 there was no sign of . . . some larger principle limiting the States in matters that relate to foreign affairs." Henkin, supra, n.43 at 238.

[53] Id. at 432.

[54] Id. at 435-40.

[55] Id. at 440.

foreign governments.[56] In sum, the Court concluded that the Oregon law could not stand since it would "impair the effective exercise of the Nation's foreign policy" and would have "a direct impact upon foreign relations and may well adversely affect the power of the central government to deal with those problems."[57]

Zschernig did not establish an absolute rule barring states from acting in a manner that might influence the foreign relations of the United States. Rather, shortly after Zschernig was decided, the Court summarily reaffirmed the right of a state to adopt reciprocal inheritance legislation.[58] Thus, it is generally agreed that Zschernig requires a careful balancing of the interest of the state in a challenged action with the adverse impact that action has on foreign relations: if a state action has a significant adverse effect on foreign relations without advancing some correspondingly weighty state interest it is forbidden.[59]

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[56] Id. at 437 n.7.

[57] Id. at 440-41.

[58] Gorun v. Fall, 287 F. Supp. 725 (D. Mont. 1968), affirmed, 393 U.S. 398 (1969).

[59] See Henkin, supra, n.43, at 241; Maier, The Basis and Range of Federal Common Law in Private International Matters, 5 Vand. J. Trans. L. 133 (1971); Developments, The Supreme Court, 1967 Term, 82 Harv. L. Rev. 63, 245 (1968).

[Footnote continued on following page]

So, in Zschernig the Oregon statute could not stand since the seizure by a state of an alien's property out of distaste for the form of government of the alien's homeland significantly disturbed this Nation's foreign relations without advancing any proper state interest.

[Footnote 59 continued from preceding page]
Zschernig has been applied, most prominently, in cases concerning the constitutionality of state "Buy American" legislation, which directs that a preference be given to American-made products in state procurement. In a decision rendered shortly after Zschernig, a lower state court in California held that state's statute unconstitutional because of its impact on foreign relations. Bethlehem Steel Corp. v. Board of Commissioner of Dept. of Water & Power, 276 Cal. App. 2d 221, 80 Cal. Rptr. 800 (1969). The New Jersey Supreme Court, on the other hand, has upheld that state's law, rejecting the argument that state "Buy American" legislation unconstitutionally interfered in the federal foreign relations power. K.S.B. Technical Sales Corp. v. North Jersey Dist. Water Supply Comm., 75 N.J. 272, 381 A.2d 774 (1977). The court reasoned that, unlike the law condemned in Zschernig, state "Buy American" legislation did not involve inquiry into or criticism of the ideology of a foreign nation. The court also noted the law's consistency with federal policy. Id. at 783-84.

Similar questions concerning the power of a state to interfere in foreign relations have been raised in cases involving an attempt by a city to prohibit the publication of advertisements for employment in South Africa. New York Times Co. v. New York, 41 N.Y.2d 345, 361 N.E.2d 963 (1977); see Note, 16 Harv. Int. L.J. 456 (1975); Note, 15 Va. J. Int. L. 473 (197), an effort by a state to investigate or penalize businesses which comply with the Arab boycott against Israel, General Elec. Co. v. New York State Assembly Comm. on Governmental Operations, 425 F. Supp. 909 (N.D.N.Y. 1976); see Comment, The Arab Boycott and State Law: The New York Anti-Boycott Statute, 18 Harv. Int. L.J. 343 (1977), and the denial by a state university of admission to Iranian students in retaliation for Iran's seizure of the American embassy, Tavvani v. New Mexico State University, 495 F. Supp. 1365 (D.N.M. 1980).

By this calculus, state divestiture is easily distinguishable from the action condemned in Zschernig. The interest of a state in divestiture is legitimated by the presumptive right of a state to manage its own finances,[60] to determine what activities it will subsidize,[61] and to choose with whom it will deal in the marketplace.[62] Thus, a state is legitimately interested in divestiture. At the same time, because divestiture is proprietary action, and involves neither regulation nor any other onerous intrusion by a state into private affairs, the burden cast by divestiture on international relations is slight.[63] This is in marked distinction with Oregon's seizure of private property in Zschernig, which represented state interference in private affairs of the most extreme sort. At the same time, divestiture poses little threat to the foreign policy of the United States, for it is

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[60] National League of Cities v. Usery, 426 U.S. 833, 855 (1976).

[61] Maher v. Roe, 432 U.S. 464, 475-76 (1977).

[62] Reeves Inc. v. Stake, 447 U.S. 429, 438-39 (1980).

[63] Both in the abortion funding cases, supra, n.21, and the proprietary action cases, text and notes accompanying supra, n.25 to n.31, the Supreme Court reasoned that states enjoyed wide discretion in undertaking such activities because they involved little disruption of private affairs.

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1986

Physician's and Surgeon's Professional Liability Coverages and Premium Schedules

PROFESSIONAL LIABILITY COVERAGES

Explanation of Policy:

The Pure Claims-Made Policy extends professional liability protection to the physician, clinic or employee for claims reported in a single year regardless of when service is rendered as long as the incident occurred while continuously insured under claims-made with MICA. Thus, claims reported this year are covered by this year's policy; claims reported next year by next year's policy and so on.

MICA'S premium rates are derived from the historical pattern of reported claims resulting from the performance of professional services which form a "stair step" with an increasing number of claims being reported each year until the fifth year. In the first year, only about 20% of the total claims resulting from a professional service are reported; the second 47%; the third 95%; the fourth 98%; the fifth and subsequent years, about 100%.

Cost:

In keeping with the "stair step" development of claims, the rates charged for the Pure Claims-Made policy mature at the fifth year. Subsequent renewal policies are charged at the mature rates. The specific cost of coverages is shown within our table entitled CLAIMS-MADE PREMIUM SCHEDULE.

All policies issued by MICA are renewed on January 1 of each year. Your first years and renewal rates are pro-rated from the first date of coverage (inception date) of the original policy. For example, if your continuous coverage became effective on July 1, 1982, your annual renewal premium on January 1, 1986 would be pro-rated from January 1 through June 30 on the fourth year rates and from July 1 through December 31 on the fifth year rates.

Limits of Liability:

MICA's professional and optional comprehensive general liability coverages are available with policy limits of:

$200,000 per occurrence/$600,000 aggregate per calendar year.

$500,000 per occurrence/$1,000,000 aggregate per calendar year.

Tail Coverages:

Should you stop practicing or change to another insurance company, MICA guarantees availability of an unlimited Reporting Endorsement known as "tail" coverage to cover subsequent reported claims. Tail coverage must be purchased by the insured within 30 days of termination of coverage, by cancellation or non-renewal; or by termination of employment or association with the physician insured under a master group policy.

Cost:

The cost of "tail" coverage will depend upon the length of time you have been insured with MICA and will be subject to the company's rules, rates, and rating plans in effect at the time the unlimited reporting endorsement is requested.

The tail premium is quoted as a one time cost but may be paid in installments. Refer to paragraph INSTALLMENTS.

Nose Coverage:

This coverage allows a physician to enroll in MICA without purchasing tail coverage from the prior professional liability company. SUBJECT TO APPROVAL, the physician can join MICA at a rate equal to the length of time of coverage under a previous professional liability program. For example, a physician in the fourth year of coverage with another insurance company could enroll with MICA at the fourth year rate. Any reported claims arising during the term of your previous coverage would then be reported to and be covered by MICA, subject to the terms, conditions and limits of liability of the MICA policy.

This coverage is not applicable to any prior occurrences which you knew, or reasonably should have known, could or would result in a claim being made against you or any other person or organization providing professional services during the course of patient care out of which the claim arose.

You should: (a) immediately report any such potential claim to your current carrier if you are presently insured or (b) provide full details of the occurrence on your application for insurance to MICA for a coverage determination prior to policy issuance.

Retirement Benefit:

Following your 62nd birthday, and at that time having completed five consecutive years as a MICA insured, a Reporting Endorsement (tail coverage) will be issued at no extra cost.

Death or Total and Permanent Disability:

A Reporting Endorsement (tail coverage) will be issued at no extra cost because of death or permanent and total disability.

New Doctor Rule:

For physicians entering private practice for the first time following completion of medical school, residency training, military service or public health service, premiums will be discounted 25% for the first year of coverage.

Employee Coverages:

Unlike many policies, most employees are provided coverage under the MICA policy.

Employee surcharges are limited to (1) Advanced Nurse Practitioners or Physician's Assistants employed or directly supervised subject to 50% annual premium of the rating class of the physician employer; (2) employed nurse midwives are subject to 100% of the Class 3 premium; (3) directly supervised, certified registered nurse anesthetists (CRNA's) are subject to 100% Class 3 annual premium.

No additional premium charges are incurred for other employees.

Locum Tenens:

MICA provides up to 60 days of coverage annually for a temporary substitute physician - locum tenens - for surgical and non-surgical specialties. Completion of application and prior approval of MICA is required.

Part Time Practitioners:

Class 1 & 2: 35% of the scheduled annual premiums for 10 hours or less per week practice, 65% of the scheduled annual premium for 20 hours or less per week practice.

Short Term Practice Situations:

Pro-rated amount of annual premium computed on short rate tables subject to $250 minimum premium.

Comprehensive General Liability Coverages:

This optional coverage is available at $50 per physician covered, subject to the same limits of liability carried for professional liability. This coverage extends contractual and personal injury in addition to bodily injury and property damage liability protection for those injuries accidentally sustained on the office premises by the general public.

This coverage is limited to only those premises actually occupied by our insured in rendering professional services. For example, an insured occupying only one suite of a building, coverage would be limited to only that suite and not the entire building and parking lots.

Corporate/Partnership/Group Professional Liability:

This optional coverage is available at no additional charge to solo practitioners and group practices, providing each member or employed physician carries coverage through the Company. Limits of each physician's coverage must be equal to that carried by the group, and the separate limits of liability for the Corporation, does not apply to policy holders who are solo practitioners.

This form provides individual limits of liability to each physician named on the policy schedule in an amount equal to the limits of liability stated on the declarations page of the policy.

Optional Shared Limits Professional Liability Group Coverage:

This optional coverage is available through the Company for your group at reduced premium levels.

One master policy is issued with each associated or employed physician covered by endorsement. Each physician, as joins your group, will be automatically covered provided 45 days written notice is given to the Company.

Coverages are limited to the course and scope of employment or association with your group. **The combined clinic/group insureds are subject to the single limits of liability per occurrence and annual aggregate limits as procured.** Completion of the Physician's and Surgeon's Professional Liability Group Application is required, along with completion of individual application for each physician to be insured.

Discounts Per Limits of Liability*

No. Doctors in clinic	$500,000
1	0
2	9%
3	11%
4	12%
5	13%
6	14%
7	15%
8	16%
9+	17%

Installments — Deferred Payment:

Installments are subject to deposits of $1,000 or two months' annual premium. Deferred payments are available in quarterly or semi-annual installments payable: 35%, 25%, 25% and 15% quarterly or 60% and 40% semi-annually. Carrying charges are computed at 10% annual simple interest on the unpaid balance.

PHYSICIAN'S RATE CLASSIFICATIONS

Class 1
Neurology
Psychiatry — excluding ECT
Physicians — no surgery. Applies to general practitioners and physicians specialists who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abcesses or suturing of skin and superficial fascia) and who do not ordinarily assist in surgical procedures.

Class 2
Neonatology
Opthalmology (Excluding Radial Karatotomy)
Physicians — minor surgery or assisting in major surgery. Applies to general practitioners and physician specialists who perform minor surgery (including catheterization) or assist in major surgery.

Class 2-A
Emergency Medicine — including free-standing emergency care centers

Class 3
Physicians who include obstetrical procedures as any part of their practice. (May still be indicated as class 2-B on policy.)
Physicians — Major Surgery
Proctology
Otorhinolaryngology
Abdominal Surgery
General Surgery
Gynecology (No Obstetrics)
Pediatric Surgery
Thoracic Surgery
Traumatic Surgery
Plastic and Reconstructive Surgery, excluding cosmetic surgery
Urology

Class 4
Anesthesiology (subject to restrict endorsement)

Class4-A
Physicians — Major Surgery
Therapeutic Radiology
Obstetrics — Gynecology
Cardiovascular Surgery
Hand Surgery
Plastic and Reconstructive Surgery, including cosmetic surgery
Vascular Surgery
Orthopedic Surgery, excluding total joint procedures, spinal surgery and insertion of prosthetic devices.
Opthalmology (including radial karatotomy)

Class 5
Physicians — Major Surgery
Neurosurgery
Orthopedic Surgery including total joint procedures, spinal surgery and insertion of prosthetic devices.

CLAIMS-MADE PREMIUM SCHEDULE

Effective January 1, 1986

LIMITS OF LIABILITY: EACH CLAIM AND ANNUAL AGGREGATE

	1st—5th Years Retroactive Dates	$200,000/$600,000 Annual Premium	$500,000/$1,000,000 Annual Premium
Class 1			
1st year rates	Jan. 1, 1986	2,020	2,394
• 2nd year renewal rates	Jan. 1, 1985	3,141	4,016
• 3rd year renewal rates	Jan. 1, 1984	4,986	6,639
• 4th year renewal rates	Jan. 1, 1983	5,089	6,786
• 5th year renewal rates	Jan. 1, 1982	5,151	6,874
Class 2			
1st year rates	Jan. 1, 1986	2,692	3,632
• 2nd year renewal rates	Jan. 1, 1985	4,933	6,437
• 3rd year renewal rates	Jan. 1, 1984	8,098	10,919
• 4th year renewal rates	Jan. 1, 1983	8,275	11,169
• 5th year renewal rates	Jan. 1, 1982	8,380	11,318
Class 2-A*			
1st year rates	[illegible] 1, 1986	4,039	5,046
• 2nd year renewal rates	[illegible] 1, 1985	6,981	9,205
• 3rd year renewal rates	Jan. 1, 1984	11,654	15,810
• 4th year renewal rates	[illegible] 1, 1983	11,915	16,178
• 5th year renewal rates	[illegible] 1, 1982	12,070	16,398
Class 3			
1st year rates	Jan. 1, 1986	5,115	6,461
• 2nd year renewal rates	Jan. 1, 1985	9,029	11,973
• 3rd year renewal rates	Jan. 1, 1984	15,211	20,701
• 4th year renewal rates	Jan. 1, 1983	15,555	21,187
• 5th year renewal rates	Jan. 1, 1982	15,760	21,477
Class 4			
1st year rates	Jan. 1, 1986	7,403	9,466
• 2nd year renewal rates	Jan. 1, 1985	13,380	17,855
• 3rd year renewal rates	Jan. 1, 1984	2[illegible],768	31,094
• 4th year renewal rates	Jan. 1, 1983	25,291	31,832
• 5th year renewal rates	Jan. 1, 1982	23,602	32,271
Class 4-A			
1st year rates	Jan. 1, 1986	8,346	10,704
• 2nd year renewal rates	Jan. 1, 1985	15,172	20,277
• 3rd year renewal rates	Jan. 1, 1984	25,880	35,373
• 4th year renewal rates	Jan. 1, 1983	26,476	36,215
• 5th year renewal rates	Jan. 1, 1982	26,831	36,716
Class 5			
1st year rates	Jan. 1, 1986	11,441	14,770
• 2nd year renewal rates	Jan. 1, 1985	21,060	28,235
• 3rd year renewal rates	Jan. 1, 1984	36,105	49,434
• 4th year renewal rates	Jan. 1, 1983	36,942	50,616
• 5th year renewal rates	Jan. 1, 1982	37,440	51,319

Family Pract — "exposure" — MICA

Underwriting

tail 21,000

first (add 40% to 3rd 1,000,000 premium)

CLAIMS-MADE PREMIUMS PREPARED BY MILLIMAN & ROBERTSON, INC., CONSULTING ACTUARIES FOR THE MEDICAL INDEMNITY CORPORATION OF ALASKA, ARE BASED ON A FIVE-YEAR PRICING STEP FOR REPORTED CLAIMS ADJUSTED ANNUALLY FOR CLAIMS EXPERIENCE.

*RETROACTIVE DATES AND RENEWAL PREMIUMS APPLY TO 2ND THROUGH 5TH YEAR ANNUAL RENEWAL WITH THE FIRST DATE OF THE ORIGINAL POLICY (INCEPTION DATE) EFFECTIVE ON OR WITHIN THE CALENDAR YEAR FOLLOWING THE RETROACTIVE DATE SHOWN. FIRST YEAR PHYSICIANS ARE SUBJECT TO FIRST YEAR RATES.

ALL POLICIES ARE RENEWED EACH YEAR ON JANUARY 1. ALL 1ST YEAR AND RENEWAL PREMIUMS ARE PRORATED SUBJECT TO THE FIRST DAY OF COVERAGE (INCEPTION DATE) UNDER THE ORIGINAL POLICY.

NOTE: IF 10% OR MORE OF THE PHYSICIAN'S PRACTICE IS IN A SPECIALTY WITH A HIGHER CLASS THAN HIS NORMAL SPECIALTY, HE OR SHE WILL BE PLACED IN THE HIGHER SPECIALTY FOR RATING PURPOSES.

AMERICAN COLLEGE OF NURSE-MIDWIVES,
ALASKA CHAPTER

March 9, 1986

Senator Bettye Fahrenkamp
Chairman, Senate HESS Committee
Alaska State Legislature
Pouch U (MS 3100)
Juneau, Alaska 99811

Dear Senator Fahrenkamp:

Thanks for your continuing interest in nurse-midwifery. I am following various bills and hearings regarding liability insurance and am hopeful that some form of relief will be considered this session.

I met with Art Stanford at MICA on February 24th. I am pleased to report that he is willing to support nurse-midwives in their request for consideration as providers eligible for MICA coverage.

MICA's Underwriting Committee based their decision regarding high ($6,461- 21,477) premium rates for certified nurse-midwives on risk 'exposure' and hypothetical 'loss risk'. A national audit done for the American College of Nurse-Midwives reviewed suit data and loss figures for the past 10 years. Monetary losses to the insurance companies involved were minimal for the 65 cases reviewed.

Mr. Stanford indicated that this information will be very helpful to the Underwriting Committee. He also indicated that it is likely that our premium rates will be lower than those on the current premium schedule.

His favorable reception to certified nurse-midwives and his willingness to work with us, gives the Alaskan ACNM membership new hope regarding liability insurance availability and affordability.

I am requesting that you consider introduction of your draft amendment dated 10-3-85, entitled "An Act relating to providing for medical malpractice insurance for nurse midwives." I believe there is still time to introduce new legislation if it is done at the committee level. If I am incorrect, please advise me of any alternatives.

I will be awaiting your reply.

Sincerely,

Marilyn Pierce-Bulger, RN, MN, CNM
Chairman, Alaska Chapter, ACNM
Box 9416 Hiland Road
Eagle River, Alaska 99577
wk 265-9245 hm 694-6076

Enclosure (1)

Reed 2-18-86

ASSOCIATION OF THE AMERICAN

COLLEGE OF NURSE MIDWIVES

CLAIM AUDIT

By: Marilyn P. Driesen

Philadelphia Claims
Manager

November 30, 1985

Alexsis

Risk Management Service

TABLE OF CONTENTS

I. Scope of Audit

The audit was conducted at the home offices of Interstate National Corporation (Chicago Insurance Company) in Chicago, Illinois; Mutual Fire Marine and Inland Insurance Company, in Philadelphia, Pennsylvania; and The Home Insurance Company, in New York City, New York.

The file review was to study all files for reserve adequacy and technical procedures of the respective carriers for the insured program years of 1976 through present.

Total files reviewed amount to 65.

II. Extent and Purpose of Audit

The purpose of the audit was to determine the propriety of reserves and the reserving procedures employed by the three insurance carriers for their respective policy periods.

At the same time, there was an analysis of the technical quality and the claim service being rendered.

III CHICAGO INSURANCE COMPANY

An audit was conducted on November 11,12,13,14 and 15, 1985 at the offices of Interstate National Corporation, 55 East Monroe Street, Chicago, Illinois 60603. Telephone number (312) 346-6400. The Claim Manager is Jack Knish.

Chicago Insurance Company was the carrier for several years. The expiration date was June 30, 1983.

Total files reviewed were 50. Present pending files are 21.

All claims reviewed were handled by staff adjusters, and reviewed on a monthly diary by supervisory personnel.

Reserves were reviewed and found to be adequate. Reserve recommendations were presented to supervisor for approval and/or comment.

All files are seen on monthly diaries, noted by both supervisor and adjuster. With their internal claim file review system, I find it would be difficult to have a claim file go for a period of a few months without being seen.

Mail was matched immediately to files and the files that warranted the excess carrier being notified was also done.

Investigations for the most part were adequate and done in a timely manner.

There were a few files which I commented on, if I felt the reserves may be low. Those you will see on the individual work sheets.

Most of the files reviewed exhibited confirmation of special damages, negotiations and work product.

Files were neat in chronological order. A very effective and efficient claim operation.

HOME INSURANCE COMPANY

An audit was conducted on November 21,22 and 23, 1985 at the offices of Home Insurance Company, 59 Madison Lane, New York City, New York 10039. The telephone number is (212) 530-7000. The Supervisor in charge of the medical/ professional liability unit is Patricia L. Page.

Of the three offices I visited, this was the least organized. There were 22 files to be reviewed. All offices were notified at the same time and the Home Insurance Company was the last audit to be completed.

Out of the 22 files, I only saw 8 files.

The reason for this is due in part to their assigning the claim to the closest office where it occurs.

This in itself is not a problem, however, there is no one person monitoring the files.

The individual files reviewed were adequate, work product was evident, and in some instances good. (Some files were given to independent adjustment companies for statements, follow up, etc.)

Reserves on files seen were adequate, there are still files which need to be developed, (however, that is not necessarily the fault of the adjuster, but in the legal system).

As with the other carriers, if I noted deficiencies I noted them on the work sheet.

The remainder of the files are being sent to me express mail from the Washington, Texas and California. When received I will complete Home Insurance Company audit.

THE MUTUAL FIRE MARINE AND INLAND INSURANCE COMPANY

An audit was conducted on November 18, 1985 at the offices of the Mutual Fire Insurance Company, UMI Building, 1760 Market Street, Philadelphia, Pennsylvania 19103. Telephone number (215) 563-7100. The Claim Manager is Paul Dooley.

Master Policy Number GA043288. July 1, 1984 through July 1, 1985. Master policy with all individual insureds expiring by December 31, 1985.

Number of Insureds: 1,299

Total Incidents Reported: 7 To Date

The present pending claim count is 7 files. All incidents are set up as claims. All claims which are sent to Mutual Fire, are given to an independent claims service for handling. The major reserving responsibility rests with the adjuster handling the file. I found the reserving practices to be good. As you are aware, these are initial reserves and are fairly realistic for the information available at this time.

Investigation was found to be timely. And reserve adjustments were made up or down within a reasonable amount of time of when it became known previous reserves were unadequate.

I did note in the files reviewed different adjusters make reserve recommendations. To be consistent, I believe reserves should be made by the supervisor involved with those files, or at least input should come from that person.

Investigations were good and leave little to be criticized, at this point in time. These files are far from being developed to their fullest potential, but there appears to be a good grasp on knowledge known to date.

Again, as with the reserving, I did not see any input from a supervising authority figure. I believe that is necessary so that the files do not lose direction or proper development.

SUMMARY OF RESULTS

The files reviewed in total have been from various states.

They are as follows:

STATE	CLAIMS PRESENTED
Florida	11
Pennsylvania	9
New York	7
California	6
Minneapolis	4
Maryland	3
Colorado	3
Connecticut	2
New Mexico	2
Georgia	2
Massachusetts	2
Texas	2
Arizona	2
Illinois	1
North Carolina	1
Delaware	1
Wisconsin	1
Utah	1
Louisianna	1
Mississippi	1
Virginia	1
New Jersey	1
Arkansas	1

AMERICAN COLLEGE OF NURSE-MIDWIVES
PROFESSIONAL LIABILITY LOSS EXPERIENCE HISTORY

Year Carrier	Number Claims	Status Open	Status Closed	Current Indemnity	Reserves Expense	Paid Indemnity	Expense
1979 (Chicago)	2	-	2	$ -0-	$ -0-	$ -0-	-0-
1980	1	1	-	$ 15,000.00	$ 9,237.14	$ -0-	$ 10,882.00
1981	14	8	6	$ 87,795.00	$41,311.00	$ -0-	$ 19,635.00
1982	22	5	17	$247,100.00	$30,282.00	$565,741.00	$114,197.00
1983	11	7	4	$ 36,500.00	$ 9,779.00	$ 33,750.00	$ 21,264.00
1984 (Home)	8	7	1	$127,500.00	$ -0-	$ -0-	Home Ins. Not Tracking Expenses
1985 (Mutual)	7	5	2	$ 13,500.00	$ 2,150.00	$ -0-	$ 1,628.15
				$527,395.00	$92,759.14	$599,491.00	$ 167,606.15

32 closed cases = paid out + expenses
6 years
3 companies

CONCLUSIONS

Overall, as with all the files reviewed, the liability for a majority of the claims for Nurse Midwives is limited in respect to exposure. Most times the circumstances involving the Nurse Midwives in claims are hospital/medical center type settings (66%).

In those files you find liability is generally shared with the physicians, and/or hospital and staff.

The Birth Centers (19%), Physician Offices/Laboratories and Home settings make up the balance (15%).

98% of the files reviewed, the Nurse Midwives are employed, and in most cases their coverage is secondary to their employer.

While I did not find claims handling consistency in every carriers' office, the deficiencies cited do not carry enough impact to alter my conclusion that the files are deemed satisfactory.

AMERICAN COLLEGE OF NURSE-MIDWIVES,
ALASKA CHAPTER

March 9, 1986

Mr. Art Stanford, Manager
Medical Indemnity Corporation of Alaska
Alaska USA Office Building
4000 Credit Union Drive, Suite 525
Anchorage, Alaska 99503

Dear Mr. Stanford:

As a follow-up of our meeting at your office on February 24th, I am writing to request that MICA consider the inclusion of certified nurse-midwives (CNM's) as a provider group eligible for liability insurance coverage with your corporation.

I understand that MICA will probably need an amendment to AS 21.88.030, 050, 080, and 900. Senator Bettye Fahrenkamp has written draft legislation and I will be contacting her to determine the best way to set the amendment process in motion.

I know that certified nurse-midwives may currently obtain liability insurance through MICA if they are an employee of a MICA covered physician. However, there are certified nurse-midwives who work with physicians who do not carry their own liability insurance. In addition, Alaska statutes that cover certified nurse-midwives as Aduanced Nurse Practitioners, do not require the CNM to be an employee of a physician. The certified nurse-midwife must show proof of her collaboration/referral process. As an example, the law would allow a group of certified nurse-midwives to form their own business. Nurse-midwives need their own affordable liability coverage.

In the past, the American College of Nurse-Midwives (ACNM) has held a master group liability policy for its members wishing coverage. Mutual Fire, Marine and Inland Insurance Company of Philadelphia terminated that policy as of July 1, 1985 due to problems with the 'reinsurance' industry. (See attached Fact Sheet: Nurse-Midwives and the Malpractice Insurance Crisis.)

STATE OF ALASKA 1986 LEGISLATIVE SESSION
FISCAL NOTE

Revision Date: _____

REQUEST

Bill/Resolution No.: CSHB 522 (L&C)
Title: Relating to payment of premiums, cancellation of policies, and medical malpractice insurance for nurse midwives
Sponsor: Labor & Commerce
Requester: _____
Date of Request: _____

FISCAL DETAIL

Agency Affected: Commerce & Economic Development
BRU: Insurance
Components: Public Protection

EXPENDITURES / REVENUES: (Thousands of Dollars)

OPERATING	FY 86	FY 87	FY 88	FY 89	FY 90	FY 91
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:

FULL-TIME						
PART-TIME						
TEMPORARY	-0-	-0-	-0-	-0-	-0-	-0-

ANALYSIS: Attach a separate page if necessary.

Prepared by: John L. George, Director
Division: Division of Insurance
Phone: 465-2515
Date: April 14, 1986

Approved by Commissioner: Lowell L. Summers
Agency: Commerce and Economic Development
Date: April 14, 1986

Distribution (by Agency preparing fiscal note):
- Legislative Finance
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)

10/25/85

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*FAIRBANKS OFFICE
**JUNEAU OFFICE
***VALDEZ OFFICE

March 11, 1986

Representative Mike Navarre
Alaska State Legislature
Pouch V (MS 3100)
Juneau, Alaska 99811

Re: House Bill 522

Dear Representative Navarre:

I am writing to you on behalf of State Farm Insurance Company and Allstate Insurance Company to register our opposition to House Bill 522. Of all the legislation pending, this legislation, if enacted, would by far have the most significant adverse effect on the insurance industry. We want to explain the reasons why we oppose House Bill 522, as well as what we believe the practical effect of that legislation will be.

The Unfair Claims Settlement Practices Act, as it presently exists, was passed to regulate claims settlement practice. This legislation was introduced by Governor Hammond in 1976, and his intent in introducing this legislation is clear from the letter he sent which accompanied the bill:

> The bill gives the director of the division of insurance authority to investigate complaints and issue orders requiring persons to stop acts or practices in violation of the chapter. Once an order is issued, the bill provides that the director may also order a penalty of as much as $10,000.00 for each violation of the chapter and suspend or

> revoke the violator's license. In addition, the bill gives the director authority to seek injunctive relief to aid in the enforcement of the chapter.
>
> This bill is a strong, consumer-oriented measure which gives the director of the division of insurance more power to deal with unfair and deceptive practices than he presently has. The remedies in this bill provide broad relief to the insurance consumer through the insurance director.

Vol. I House Journal 1976, at 24. (Emphasis added).

As you can see from this letter, the legislation granted to the Director of the Division of Insurance broad authority to investigate and regulate claims settlement practices. It is significant that even this authority was based upon the premise that a single instance was not itself a violation, but a violation occurs only where the acts are committed with such frequency to indicate a practice.

House Bill 522 would change the focus of the original legislation, and would instead allow a claimant a private civil cause of action based upon a single violation of this act. Furthermore, House Bill 522 would allow a third-party claimant a private civil cause of action based upon a single violation of this act. The practical ramifications of the enactment of House Bill 522 are thus significant, for the Bill would create a private civil cause of action in cases where such a cause of action is not presently recognized.

If House Bill 522 is enacted, virtually every time there is disagreement about liability or damages, there will be the potential for a private civil cause of action based on an alleged violation of the Unfair Claims Settlement Practices Act. That this will occur is evident from a simple examination of the mechanics of the settlement process in a typical liability case. Every case that involves a settlement arises from an occurrence which allegedly caused injury to a third party. In every such case, two questions must be addressed before there can be a settlement: (1) Whether the insured was liable, and if so, the extent of his or her liability; and (2) The damages caused to the third party by the insured. In many cases, the questions of liability and damage are relatively clear, however in many others, those questions are not.

For example, Alaska has adopted judicially the concept of comparative negligence. This concept in essence provides that the party bringing the claim may be at fault as well, and that to the extent that party is at fault, he or she may not recover damages from the other side. The concept of comparative negligence requires a percentage allocation of responsibility to the party bringing the claim if that party was at fault. Many times, whether the defendant was at fault to begin with and if so, the nature and extent of the plaintiff's comparative fault are items which are legitimately and vigorously contested.

The same is true with respect to the question of damages. Since our legal system allows recovery for many types of damage that are not capable of being measured objectively, in many cases we see a significant and legitimate conflict as to the amount of damages the person is entitled to, even when liability is relatively clear. For example, one of the most difficult cases to resolve is a soft tissue neck case, and this is true regardless of whether liability is clear or not. There is no test that can be given to objectively determine the extent of the disability, and most such cases essentially turn on the credibility of the individual involved. This is also true in many other types of cases simply because there is no way to objectively measure certain types of damage such as pain and suffering.

If House Bill 522 is passed, an insurer would be exposed to a lawsuit virtually every single time a settlement offer made by a plaintiff is refused. Examples of such lawsuits in other states are numerous. For example, California has an Unfair Claims Settlement Practices Act which allows a private cause of action. In a recent case there the insurer refused a settlement offer made by the plaintiff, and the case proceeded to trial. Even though the jury ultimately awarded the plaintiff only one-fifth of that amount, the California Court still held the insurer could be found liable for failing to make proper efforts to settle the case.

It is virtually impossible to calculate the cost of such a system, for virtually every case that is settled would be settled under the shadow of an Unfair Claims Settlement Practices Act threat. Frankly, this is just about the worst thing that could be done by the legislature at a time when many insurance carriers have left the Alaska market, and the price of liability insurance has continued to rise. Instead of providing disincentives for insurers to do business in Alaska the legislature should provide incentives.

As our system presently exists, there are tremendous incentives for insurers to expeditiously resolve cases. First of all, prejudgment interest presently runs at a rate of 10.5% per annum, and this alone is a significant incentive for an insurer to expeditiously resolve a case. A second incentive for an insurer to resolve a case is simply the cost of litigation and the cost of claim handling. If an insurer can settle a case for a fair amount promptly, the insurer avoids the cost of having its claims adjustor continue to deal with that case, and furthermore avoids the significant legal fees that occur in the defense of virtually any personal injury lawsuit. A third incentive is the desire of both parties to avoid Rule 82 attorneys fees. Yet an additional incentive is the statutory offer of judgment that parties can file pursuant to AS 09.30.065. If a plaintiff files such an offer of judgment and this offer is not accepted, and the plaintiff then recovers a larger amount than the offer, the plaintiff recovers an additional 2% in interest, for a total of 12.5% per annum, from the time of the occurrence. These are significant incentives which are already present in our system which encourage both parties to expeditiously resolve claims, and frankly the system works well, for only a very small percentage of cases ultimately proceed to the courtroom.

If HB 522 is passed, the legislature in effect will create a new cause of action on the part of plaintiffs directly against insurance carriers. However, the legislature will be doing nothing to encourage plaintiffs to act more fairly and expeditiously in resolving disputes. It takes two parties to settle, and this legislation would govern the conduct of the insured party, but not the other party. If anything, the legislature should provide incentives for <u>all</u> parties, insured or not, to promptly and fairly resolve claims.

We know problems with claims have occurred in the past, and we suspect there will be occasional problems in the future, but disagreement is inherent in the adversarial system of justice. That system is now equally balanced, since neither a plaintiff nor an insured defendant may sue the other side for lack of good faith in negotiation. The passage of HB 522 would change that balance.

The cost and availability of insurance is one of the most significant problems facing the legislature this year. Passage of HB 522 will complicate rather than assist the resolution of this problem. We strongly feel that claims settlement practices should continue to be overseen by the Division of Insurance through the broad powers granted by the

present act. We thank you for the opportunity to comment on this issue.

Sincerely,

HUGHES THORSNESS GANTZ
POWELL & BRUNDIN

By: John T. Frank for
Michael L. Lessmeier

MLL/mh
0419A

cc: Members of the House Labor and Commerce Committe

RECORDS CERTIFICATION

I, the undersigned, an employee of the State of Alaska, do hereby certify that the microfilm images on this microform are accurate reproductions of the original records of the State of Alaska as accumulated during the regular course of business, and that it is the established policy and practice of this State to microfilm its records and to dispose of the original records after microfilm reproductions have been made.

James O. Smith
Signature of Camera Operator

9/5/89
Date

02-519 (REV 8/78)