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1 IN THE SENATE

BY KERTTULA

2 ~~SENATOR~~ SUBSTITUTE FOR SENATE BILL NO. 235

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 FIFTEENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act relating to the medical malpractice liability
7 revolving loan fund."

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

9 * Section 1. AS 21.88.210 is amended by adding new subsections to read:

10 (e) Interest paid on loans under (b) of this section, including
11 interest paid on notes purchased by the Department of Revenue under
12 (d) of this section, shall be deposited in the general fund. The
13 Department of Administration shall separately account for deposits
14 made by the corporation or the Department of Revenue under this sub-
15 section. The annual estimated balance in the account may be appro-
16 priated by the legislature for the purpose of providing grant funds
17 for the cost of liability insurance for ~~acute care~~ hospitals with a
18 patient capacity of not more than 40 acute care beds.

19 (f) When an appropriation is made under (e) of this section, the
20 director shall provide notice of the availability of the grant funds
21 and an application to each hospital in the state with a patient
22 capacity of not more than 40 acute care beds. The grant funds shall
23 be disbursed among those applicants applying within 30 days after
24 receiving notice of the availability of the grant funds from the
25 director. Each eligible applicant shall receive a percentage of the
26 total grant funds available that corresponds to that applicant's
27 percentage of the total number of acute care beds of all eligible
28 applicants. An applicant may not receive under this subsection an
29 amount of money greater than its cost of liability insurance for the

1 current year.
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M I C A

**1985
Tenth Annual Report**

Medical Indemnity Corporation of Alaska

CORPORATE DIRECTORY

Board of Governors

David J. Frazier
Chairman of the Board
William G. Brock
First Vice Chairman
Robert D. Whaley, M.D.
Second Vice Chairman
David S. Grauman, M.D.
Frederick R. Hood, M.D.
Renee Murray
Mary A. Pierce
Jane Sabes
Kim C. Smith, M.D.

Board of Governors Committees

Executive Committee
David J. Frazier - Chairman
William G. Brock - 1st Vice-Chairman
Robert D. Whaley, M.D.
2nd Vice-Chairman

Audit Committee
David S. Grauman, M.D. - Chairman
Kim C. Smith
Frederick R. Hood, M.D.

Claim Committee
Renee Murray - Chairman
Frederick R. Hood, M.D.
Robert D. Whaley, M.D.

Computer Committee
Robert D. Whaley, M.D. - Chairman
Frederick R. Hood, M.D.
David S. Grauman, M.D.

Finance & Investment Committee
William G. Brock - Chairman
Mary Pierce
Jane Sabes

Underwriting Committee

Mary Pierce - Chairman
David S. Grauman, M.D.
Renee Murray
Jane Sabes
Robert D. Whaley, M.D.

Legislative Committee

Kim C. Smith, M.D. - Chairman
Robert D. Whaley, M.D.
William G. Brock

Risk Management Committee

Frederick R. Hood, M.D., - Chairman

Advisory Panel:

William Compton, M.D.
Scott Emery, M.D.
Hedric Hanson, M.D.
Kitchener Head, M.D.
Burton Janis, F.
Warren Jones, J.D.
Ron Keller, M.D.
Lorraine Kottra, M.D.
Scott Sims, M.D.

Corporate Office

Alaska U.S.A. Office Building
4000 Credit Union Drive, Suite 525
Anchorage, Alaska 99503

Administration

Peter J. Volpe, Director
Vice President
Marsh & McLennan, Incorporated
720 Olive Way
Seattle, Washington 98101
(206) 223-1240

Local:

Arthur M. Stanford
Manager/Assistant Director
4000 Credit Union Drive
Anchorage, Alaska
(907) 563-3414

Janet Sloan Johnston, R.N., M.S.N.
Assistant Director

Staff

Donnette Olsen Norman
Office Manager

Joe McKay
Amy Murphy
Herriett Larson

Actuaries

David R. Bickerstaff, F.C.A.S.
Milliman & Robertson, Incorporated
251 South Lake Avenue, Suite 400
Pasadena, California 91101

Auditors

Ernst & Whinney
301 W. Northern Lights Blvd., Suite 601
Anchorage, Alaska 99501
(907) 279-1411

Corporate Counsel & Secretary

Roger F. Holmes, Esq.
BISS & HOLMES
705 Christensen Drive
Anchorage, Alaska 99501

Assistant Corporate Secretary

Patricia Baker
3120 Bettles Bay Loop
Anchorage, Alaska 99502

Data Services

Mark Bolzern
General Computer Services
200 W. 34th Avenue, Suite 798
Anchorage, Alaska 99503
(907) 563-2707

Investment Consultants

Donald E. Boyd
Vice President
Wells Fargo Investment Advisors
P.O. Box 44029
San Francisco, California 94144
(415) 396-6436

Reinsurance Intermediary

Kendel Lyman - Vice President
Marsh & McLennan, Incorporated
720 Olive Way
Seattle, Washington 98101
(206) 223-1240

Cravens & Company, S.I.S.
800 5th Avenue, #378
Seattle, Washington 98104

Reinsurers

Certain underwriters at Lloyds,
British Companies

Domestic:

Health Providers Insurance Co.
211 E. Ontario
Chicago, Illinois 60611

Risk Management Consultant

Robert S. Brittain, M.D.
President
Medical Liability Consultants Program
Bldg. 2, Suite 199
6825 E. Tennessee
Denver, Colorado 80224
(303) 321-3884

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CLAIMS

The graph to the right illustrates the continuing escalation of claims reported by MICA policyholders since the company's incorporation in 1976.

We have added a new column for 1985 entitled, "Suspense Files" as distinguished from reported claims. This new category relates to incidents reported to MICA which have some elements realistically associated with a legitimate claim, but no claim has actually been made to date. Although these potential claims are thoroughly investigated to provide the best possible defense to our insureds, they continue to be termed "suspense" files until the patient or the patient's attorney actually makes a demand for compensation. An exception to this rule is to open a claims file when the medical misadventure resulted in serious consequences and in our judgement, will most likely result in a demand for compensation at some future date.

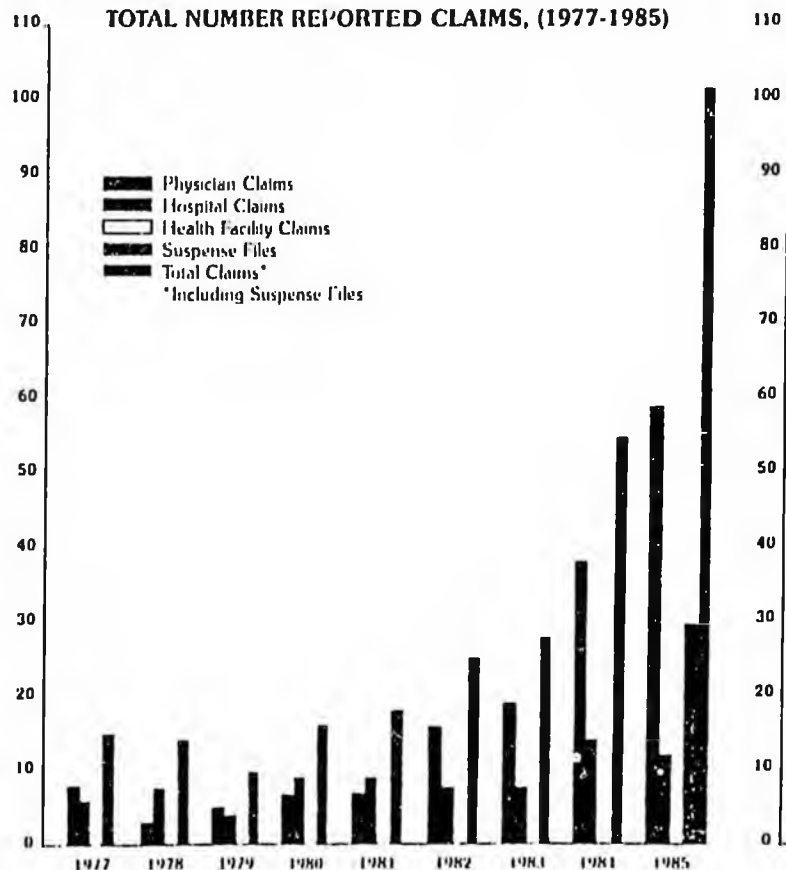
MICA remains the only medical malpractice insurance carrier in Alaska with a local, "in-house" Claims Department. Our Claims Department is staffed by a registered nurse who conducts all initial investigations of potential claims. She is supported and assisted by MICA's manager who has a background of over 30 years of casualty claims experience. She also draws upon the medical expertise of the physicians on the MICA Board of Governors and Risk Management Committee.

The first steps taken by MICA's Claims Administrator on a newly reported claim are to conduct an in-

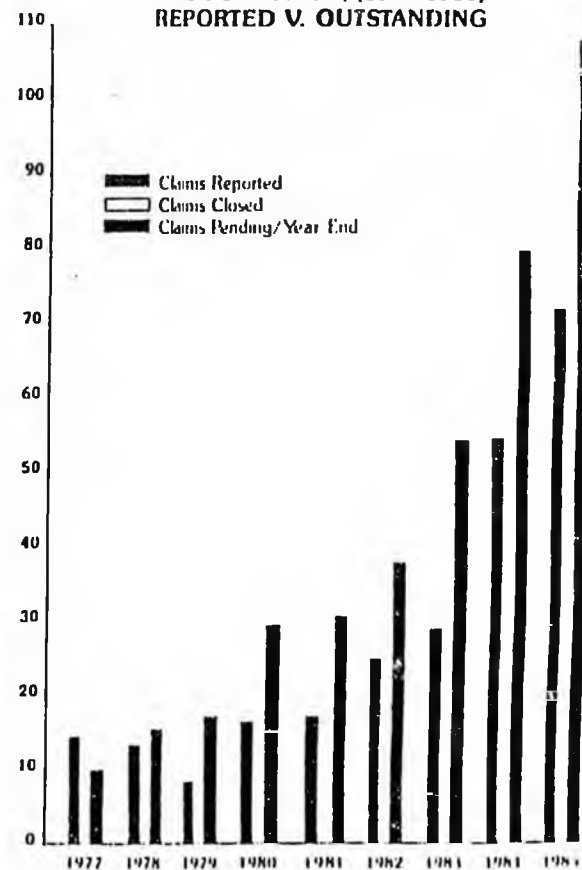
depth review of the factual situation with the policyholder, and to consolidate all of the available medical records on the case. This initial information and documentation is provided to one or more physicians of the same medical specialty as our insured, for an opinion on whether the facts indicate the standard of care was met under the circumstances. This initial investigation and peer review opinion provides a swift and solid foundation upon which the defense of the case can be built. Conversely, it can also provide the basis for prompt settlement if the facts prove the claim to be meritorious.

MICA's unique ability to respond to the urgent needs of our policyholders when a real or potential claim arises, cannot be overemphasized. Our claims staff knows Alaska, they know our physicians, they know our entire health care provider community, and most importantly, MICA is recognized as the dominant writer of medical malpractice insurance in Alaska that will vigorously resist the demands of its adversaries all the way to the jury, if necessary, on frivolous and non-meritorious claims.

TOTAL NUMBER REPORTED CLAIMS, (1977-1985)



CASE SUMMARY, (1977-1985) REPORTED V. OUTSTANDING



RISK MANAGEMENT

Risk Management at MICA had its real beginning in December 1983 with the hiring of Janet Johnston, R.N., M.S.N., as the MICA staff person charged with the responsibilities of investigation/resolution of claims along with the institution of a Risk Management program. Ms. Johnston's experience in clinical nursing and as a nursing administrator and consultant, was further augmented by MICA's exclusive Alaska contract with Dr. Robert Brittain of Denver, Colorado, a nationally recognized pioneer and leader in the field of medical malpractice Risk Management. In 1984, MICA's Risk Management Committee was formed, bringing together seven physicians from the Alaskan medical community, each recognized as a leader in his or her field of medical practice. Three other physicians have since joined the Committee, and several others have been asked to serve from time to time to meet special needs and to provide special expertise to the Committee and the Risk Management program.

The initial thrust of the Risk Management Committee was to begin educating itself by reviewing past as well as new claims in an attempt to delineate those risk management factors which were involved. In addition, the members of the Risk Management Committee were able to meet with and to review their efforts with Dr. Brittain.

Risk Management is primarily an educational venture, one of identifying those factors which are instrumental in either provoking or preventing claims and, once identified, of educating physicians as to those factors and as to the means of either countering them or

using them to provide a viable defense. To this end, the Risk Management Committee has been involved in the following:

1. Seminars, utilizing both medical and legal personnel: in one instance to speak to relevant Risk Management issues as viewed from both the plaintiff's and defendant's side of the issue and in another, to discuss the proper management of the litigation process itself from the physician's standpoint.

2. Individual presentations to the medical and nursing staffs of our insured hospitals, using the services of Ms. Johnston and one or more members of the Risk Management

Committee.

3. Circulation of a growing library of videotapes of the seminars and of tapes made for MICA by Dr. Brittain on specific topics of Risk Management importance.

4. MICA Risk Management Bulletins featuring articles on Risk Management written by Ms. Johnston and members of the Risk Management Committee or reprinted from other Risk Management periodicals published by the insurance industry.

Unfortunately, the principle of "tell 'em, tell 'em again, then tell 'em what you told 'em," though valid in concept,

is just not enough!

Recently, the MICA Board of Governors' Chairman wondered aloud as to whether the Risk Management program was reaching the point of diminishing returns. While it is premature to attempt to judge the effects of a risk management program (barely 21 months old), claims continue to occur, often as the direct result of the failure to observe basic risk management principles, while other claims prove indefensible in the face of good medicine for the very same reasons.

While no claim is the sole result of a single factor, it is estimated that in excess of 40% of the claims presently



UNDERWRITING

Determining adequate premium levels as well as establishing and maintaining criteria for insurability are the key functions of the Underwriting Department and they form the financial foundation upon which a fiscally sound insurance company is built.

Each year MICA carefully analyzes the balance between its income derived from earned premiums (and secondarily from investment return) as opposed to both actual and anticipated expenditures. These include: claims settlements, reinsurance costs, plus normal operating expenses in addition to incurred liabilities in reserving the estimated costs of pending claims.

In 1985, MICA's expenditures exceeded income from all sources, and policyholder surplus was utilized to offset this deficiency. The other alternative would have been to implement mid-term premium increases which the MICA Board of Governors rejected in favor of subsidizing MICA's policyholders' rates through the use of surplus.

At the close of 1985 it was apparent that premium increases were required to correct the imbalance of expenditures and incurred liabilities exceeding income. Additionally, a sufficient amount of income would have to be generated in the future to replenish policyholder surplus which acts as a financial cushion to absorb unexpected and catastrophic claims experience or other unanticipated expenses.

MICA's rate levels are not arbitrar-

ily created by the company. The fact is, that domestic insurance carriers, such as MICA, are one of the most highly regulated industries in the United States.

All rate increases must first be supported by actuarially sound documentation and then reviewed by the MICA Board of governors. The rates are then filed with the Alaska Division of Insurance for approval by the Director who can reject the filing if he determines that the rates are excessive or inadequate. Thus, rate increases must be fully supported by a need and thoroughly evaluated by the MICA staff and the MICA Board of Governors, as well as approved by the state regulatory agency before they are implemented.

MICA's underwriting guidelines were created to provide an equitable and uniform basis upon which to determine insurability. Careful underwriting is the method utilized to control the cost of insurance for the majority of our policyholders who present a normal exposure to loss. Conversely, prudent underwriting would mandate rejecting an application by a particular physician who most likely would cause other policyholders to support, to an unfair degree, that physician's claims costs.

Ultimately, the beneficiary of prudent underwriting is the physician who is professionally qualified, without a history of medical misadventures. Proper underwriting often involves very painful decisions which are taken very seriously by the MICA staff and your Board of Governors. However,

without underwriting criteria, the financial integrity of the corporation would clearly be impaired which patently would not serve the best long term interests of the corporation or our policyholders.

INVESTMENTS

Despite declining interest rates and a larger portion of its portfolio in short-term investments, MICA's net investment income reached \$1,158,000 in 1985, exceeding the 1984 figure by more than \$59,000. This increased income was attributable entirely to a 10% increase in earning assets. Additionally, with the decline in market interest rates, MICA's portfolio of notes and bonds increased in market value. At year's end, that market value exceeded by more than \$500,000 the value shown on the company's books.

MICA is entering 1986 in a very liquid position. This reflects recognition by its board of governors of the uncertainties facing the liability insurance business in the present environment, including the cost and terms of reinsurance. Nonetheless, our basic investment policy continues to emphasize high asset quality and stable returns. In 1986, as in the past, MICA's investment income will be an important and dependable supplement to its income from policyholder premiums.

ASSET COMPOSITION

	<u>Cost</u>	<u>% of Assets</u>	<u>Yield On Cost</u>
Cash Equivalents	\$1,123,816	11.4%	7.63%
U.S. Treasury Notes	4,919,412	50.1	11.34
Federal Agency Obligations	1,113,563	11.3	10.77
Corporate Obligations & Canadian Yankee Issues	<u>2,670,618</u>	<u>27.2</u>	<u>11.52</u>
Total Assets	\$9,827,409	100.0%	10.90%

MATURITY

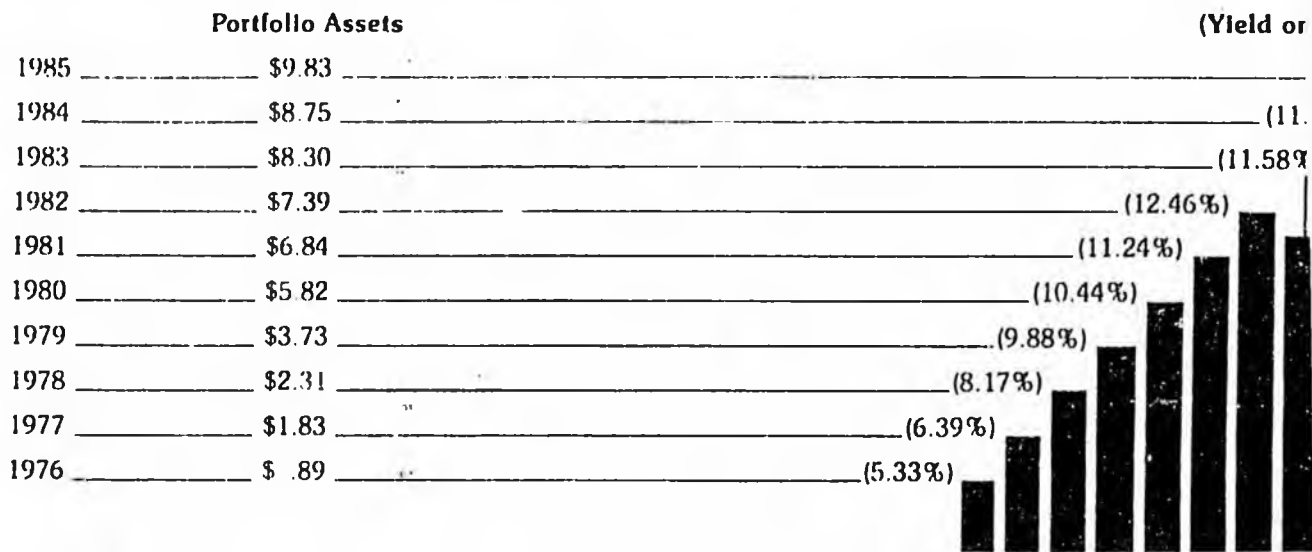
	<u>Cost</u>	<u>% of Assets</u>	<u>Yield On Cost</u>
Immediate Liquidity	\$1,123,816	11.4%	7.63%
1986	735,510	7.5	10.93
1987	1,049,203	10.7	9.09
1988	740,344	7.5	11.37
1989	694,472	7.1	10.63
1990	698,828	7.1	12.07
1991	725,203	7.4	13.49
1992	755,375	7.7	11.43
1993	980,398	10.0	11.82
1994	927,344	9.4	12.76
1995	<u>960,969</u>	<u>9.8</u>	<u>10.60</u>
Subtotal	\$9,391,462	95.6%	10.90%
	<u>435,947*</u>	<u>4.4</u>	<u>10.75</u>
Total Assets	\$9,827,409	100.0%	10.90%

* Segregated assets held to fund long term liability

INVESTMENTS

Investment Yield (Portfolio Assets)

\$ Figures for funds invested represented in millions



Net Investment Gain – (Investment income less interest expense for State of Alaska loan)

\$ Figures for net investment gain represented in thousands



FINANCIAL STATEMENTS

Medical Indemnity Corporation of Alaska

Ernst & Whinney

Board of Governors
Medical Indemnity Corporation of Alaska
Anchorage, Alaska

We have examined the balance sheets of Medical Indemnity Corporation of Alaska (MICA) as of December 31, 1985 and 1984, and the related statements of operations and changes in policyholders' surplus (deficit) and changes in financial position for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

As more fully described in Note B to the financial statements, the reserve for unpaid losses and loss adjustment expenses was determined based upon an estimate of the ultimate settlement costs of all losses and loss adjustment expenses. Management believes that the reserve for unpaid losses and loss adjustment expenses is adequate. However, no assurance can be given that the ultimate settlements will not be significantly greater or less than such estimated amounts included in the Corporation's financial statements.

In our opinion, subject to the effects on the financial statements of such adjustments, if any, as might have been required had the outcome of the uncertainty referred to in the preceding paragraph been known, the financial statements referred to above present fairly the financial position of Medical Indemnity Corporation of Alaska at December 31, 1985 and 1984, and the results of its operations and the changes in its financial position for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Ernst & Whinney

Anchorage, Alaska
February 28, 1986

FINANCIAL STATEMENTS

Medical Indemnity Corporation of Alaska

BALANCE SHEETS

December 31

1985 1984

ASSETS

Investments—Note C:

U.S. government notes and bonds—designated for retirement of note payable	\$ 606,354	\$ 546,356
U.S. government notes and bonds—undesignated	5,658,313	5,228,156
Canadian government bonds	247,422	246,875
Corporate notes	2,458,178	2,820,288
Short-term demand notes and money market investments	1,113,191	133,699
	<u>10,083,458</u>	<u>8,975,374</u>

Cash	108,953	131,427
Premiums receivable, less allowance for doubtful accounts of \$2,000 in 1985 and 1984	21,298	37,769
Accrued interest receivable	229,036	233,126
Note receivable	22,884	23,184
Account receivable—U.S. government		200,000
Computer equipment, less accumulated depreciation of \$7,418 in 1985 and \$3,548 in 1984	11,933	15,803
	<u>\$10,477,562</u>	<u>\$9,616,683</u>

LIABILITIES AND POLICYHOLDERS' SURPLUS

LIABILITIES

Unpaid losses and loss adjustment expenses	\$ 6,543,938	\$3,674,773
Deferred premiums—MCM policies		284,000
Deferred premiums—MCM policies—to be refunded	694,416	
Accounts payable and accrued expenses	143,262	150,037
Premiums received in advance	139,075	71,174
Liability to reinsurers	62,000	401,162
	<u>7,582,691</u>	<u>4,581,146</u>

NOTE PAYABLE TO STATE OF ALASKA	3,000,00	3,000,000
POLICYHOLDERS' SURPLUS (DEFICIT)	(105,129)	2,035,537
	<u>\$10,477,562</u>	<u>\$9,616,683</u>

See notes to financial statements

STATEMENTS OF OPERATIONS AND CHANGES IN POLICYHOLDERS' SURPLUS

	Year Ended December 31	
	1985	1984
Revenue:		
Premiums earned:		
Physicians	\$2,510,344	\$1,869,421
Hospitals	679,858	714,567
Related health care	141,219	109,067
	3,331,421	2,693,055
Deduct (add):		
Reinsurance ceded	897,183	1,119,692
Change in deferred premiums	410,416	(82,000)
	2,023,822	1,655,363
Interest earned, less investment expenses of \$53,794 in 1985 and \$50,458 in 1984	1,158,190	1,099,093
TOTAL REVENUE	3,182,012	2,754,456
Losses and expenses:		
Losses and loss adjustment expenses	4,587,236	2,232,720
Other underwriting expenses—Note F	525,442	411,811
Interest expense on note payable to State of Alaska—Note E	210,000	210,000
TOTAL LOSSES AND EXPENSES	5,322,678	2,854,531
NET LOSS	(2,140,666)	(100,075)
Policyholders' surplus at beginning of year	2,035,537	2,135,612
POLICYHOLDERS' SURPLUS (DEFICIT) AT END OF YEAR	\$ (105,129)	\$2,035,537

See notes to financial statements.

FINANCIAL STATEMENTS

Medical Liability Corporation of Alaska

STATEMENTS OF CHANGES

	Year Ended December 31	
	1985	1984
FUNDS PROVIDED		
From operations:		
Net loss	\$(2,140,666)	\$ (100,075)
Add (deduct) items not affecting cash:		
Increase in liabilities	3,001,545	834,933
Decrease (increase) in premiums receivable	16,471	(19,807)
Decrease (increase) in accrued interest receivable	4,090	(34,282)
Decrease (increase) in notes and accounts receivable	200,300	(167,618)
Purchase of computer		(19,351)
Amortization of bond discount	(109,857)	(88,075)
Depreciation of computer equipment	3,870	3,548
	FUNDS PROVIDED FROM OPERATIONS	409,273
Maturity of investments	2,000,000	1,065,000
	TOTAL FUNDS PROVIDED	1,474,273
FUNDS USED		
Purchase of investments	3,018,735	1,508,972
	DECREASE IN CASH	(34,699)
Cash and money market investments at beginning of year	265,126	299,825
	CASH AND MONEY MARKET	
	INVESTMENTS AT END OF YEAR	\$ 265,126
	\$ 222,144	

See notes to financial statements

NOTES TO FINANCIAL STATEMENTS

MEDICAL INDEMNITY CORPORATION OF ALASKA

December 31, 1985

NOTE A—ORGANIZATION AND OPERATIONS

Medical Indemnity Corporation of Alaska (MICA) is an insurance company created by the Alaska legislature to provide professional liability insurance to Alaskan physicians and surgeons, hospitals, and related health care organizations. MICA commenced business on June 28, 1976.

The daily operations of MICA are managed by an independent consulting firm, which is compensated on the basis of actual costs plus a management fee.

Prior to January 1, 1979, MICA issued "occurrence" basis policies which provide coverage for the policyholder for claims incurred during the policy year regardless of when the claims are reported to MICA. Since January 1, 1979, MICA has issued only "claims-made" policies which provide coverage for the policyholder for claims reported during the policy year to MICA, regardless of when the claims were incurred. Until December 31, 1985, MICA also issued a "modified claims-made" policy ("MCM") which provides coverage for the policyholder for claims reported during the first twelve months subsequent to the policy expiration date and also for claims reported during the policy year.

MICA also offers policyholders who terminate their policy the option of purchasing a "tail" (occurrence) policy which will indemnify the policyholder against future claims that occurred while a MICA policyholder.

MICA was capitalized with a note payable to the State of Alaska.

NOTE B—SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation: The accompanying financial statements have been prepared in conformity with generally accepted accounting principles which are not significantly different from accounting practices required for statutory purposes. Anticipated investment income is considered in determining if premium deficiencies exist.

Premiums: Premiums are earned ratably over the policy period to which they apply. Policies are written on a calendar year basis.

Deferred Premiums (to be refunded): Deferred premiums to be refunded are the result of discontinuing the sale of MCM policies. MICA will refund a premium to MCM policyholders at December 31, 1985 based upon the number of years the policyholder has been with MICA.

Underwriting Expenses: Underwriting costs are expensed when incurred. Due to the nature of MICA's operations, commissions and premium taxes are not significant.

Losses and Loss Adjustment Expenses: The liability for unpaid losses and loss adjustment expenses represents an estimate of the ultimate net cost of all such amounts unpaid at the balance sheet dates. The liability has been determined using case basis evaluations and statistical analyses and projections. The statistical analyses and projections have been determined by independent consulting actuaries using MICA's own historical loss data, giving effect to estimates of trends in claim frequency and severity, and are inherent in MICA's premium structure. These estimated liabilities are continually reviewed and, as adjustments become necessary, such adjustments are reflected in current operations. Although MICA believes the estimate for the liability is reasonable under the circumstances, MICA's actual incurred losses and loss adjustment expenses may vary from the amounts included in the financial statements.

Depreciation: Computer equipment is recorded at cost and depreciated over the estimated useful life of the assets using the straight-line method.

NOTE C—INVESTMENTS

Investments in government and corporate notes and bonds are carried at amortized cost. The market values of these investments were as follows:

	December 31	
	1985	1984
U.S. government notes and bonds	\$6,620,891	\$5,740,791
Canadian government bonds	290,625	260,938
Corporate notes	2,598,776	2,908,001

Short term investments are carried at cost which approximates market value.

Notes with an amortized cost of approximately \$100,000 were pledged to the Alaska Insurance Department to meet statutory requirements.

The Board of Governors has designated US government notes and bonds with an amortized cost of \$606,354 in 1985 and \$546,356 in 1984 for retirement of the note payable to the State of Alaska.

Realized gains and losses, which are not material to the financial statements, are determined on the basis of specific identification and are included in interest income for presentation purposes.

NOTE D—REINSURANCE

Loss and loss adjustment expenses incurred during 1985 for claims in excess of \$250,000 up to \$2,000,000 per occurrence are 83.5% recoverable under excess of loss reinsurance contracts. MICA remains liable for the 16.5% of excess loss not covered by reinsurance. Additionally, MICA has a deductible of \$831,000 for excess losses under their reinsurance agreements for 1985 claims.

Loss and loss adjustment expenses incurred during 1984 and prior years in excess of \$200,000 up to \$5,000,000 per occurrence are 100% covered by reinsurance agreements.

MICA would remain liable to the extent reinsurance companies are unable to meet their obligations.

Amounts which have been deducted from liability, income, and expense accounts in connection with all ceded reinsurance placed with other companies are as follows:

	1985	1984
Estimated losses and loss adjustment expense to be recovered from reinsurer	\$3,090,000	\$1,775,000
Reinsurance premiums incurred	897,183	1,119,692
Losses paid by reinsurer	1,023,149	546,994
Loss adjustment expenses paid by reinsurer	34,663	6,241

NOTE E—NOTE PAYABLE TO THE STATE OF ALASKA

The Act which created MICA provided for its capitalization through a loan of \$3,000,000 to the Medical Malpractice Revolving Loan Fund of the State of Alaska. This loan, which may not exceed \$6,000,000, is subordinated to all other obligations of MICA. The remaining \$3,000,000 available under this provision from the State is drawn on if operations demand.

Repayment of the loan is to be made in installments based upon underwriting earnings computed as specified in the Act. No repayment was due December 31, 1985 or 1984. Interest at 7% is payable quarterly.

The remaining \$3,000,000 of the available loan from the Medical Malpractice Revolving Loan Fund requires repayment within five years from the time MICA receives the additional funds. Interest on additional funds is payable at six percent.

NOTE F—MANAGEMENT AGREEMENT

MICA's daily operations are managed by Marsh McLennan, Inc. on the basis of cost reimbursement plus a management fee.

NOTE G—INCOME TAXES

MICA has received a ruling from the State of Alaska and a professional opinion that as a not-for-profit corporation created by the State of Alaska it is exempt from income taxes.

NOTE H—COMMITMENTS

MICA leases office space with an annual rental expense of approximately \$27,000 through December 31, 1985. Rental expense was \$27,000 in 1985 and 1984. MICA has renewed its present lease through December 1986.

1985 Medical Malpractice Update

By: Roger F. Holmes, Esq.

1984 was the worst year in the history of the property/casualty insurance industry. In the wake of the 1984 experience, 1985 resulted in the most violent market constriction in the history of the insurance industry. In 1985 underwriting losses continued to mount. 16% of the United States insurance industry is targeted for observation of financial problems and possible insolvencies under an industrywide early warning system.

Between 1975 and 1985 the medical malpractice field as a whole failed to turn an underwriting profit in every year except 1977. Medical malpractice premiums nationwide in 1985 rose an average of 32%. In New York, premiums for all physicians rose an average of 52%. The predictions are for similar rate increases in 1986. Lloyds of London, a substantial medical malpractice underwriter, has threatened to pull out of the United States market completely.

The New Mexico medical malpractice insurance captive which was providing insurance for Wyoming physicians pulled completely out of the State of Wyoming. In Illinois, the average jury verdict against health care providers doubled and the percentage of defense verdicts in medical malpractice cases dropped below 70% for the first time ever to 57.6%. The average jury verdict in medical malpractice cases ten years ago was \$166,000. That average has now reached \$955,000. At least 16% of all physicians nationwide are being sued each year. Of 75 perinatology programs in the United States, 45 now have vacancies. Many attribute this largely to the malpractice climate.

In the face of these dismal statistics, the push for tort reform in the '80s has

become very strong. Physicians in many states have engaged in slowdowns or otherwise refused to perform surgery in an effort to dramatize this situation. It has been estimated that if meaningful tort reform takes place in the medical malpractice field, a billion dollars a year can be saved.

In 1985 Illinois adopted a comprehensive medical malpractice tort reform package. Within very few months, a trial judge struck the entire scheme down as unconstitutional. Similarly in Louisiana and Texas portions of medical malpractice reform legislation were struck down as unconstitutional.

Conversely, the United States Supreme Court affirmed without opinion several decisions from the California Supreme Court upholding various medical malpractice reforms. What sets the 1986 tort reform movement apart from earlier movements is that many of the proposals are not limited to the medical malpractice field. This should give those reforms which are passed a much greater chance of standing constitutional scrutiny.

One short term problem with tort reform can be seen from the 1985 Illinois experience. Prior to the adoption of the medical malpractice reform, 9 to 10 medical malpractice cases were filed a day in Chicago. In the three days before the effective date of the statute, over 1,250 medical malpractice claims were filed in the City of Chicago with 725 of those suits alone being filed in the afternoon prior to the effective date of the statute. Lawyers and their staff members were standing 50 deep in six or more lines waiting to file medical malpractice cases that afternoon in order to have those cases filed before the effective date of the

reform legislation and thus be governed by the prior rules.

The focus of medical malpractice suits continues to center on the hospitals. One very good reason for this is that 80% of all medical malpractice claims arise from events occurring inside the hospital. One favorite attempt by plaintiffs is to try and hold the hospital liable under the doctrine of ostensible agency for emergency room doctors, pathologists, radiologists and other medical specialists whose practice is limited solely to the hospital. The courts are also beginning to hold hospitals strictly liable for injuries which result when equipment fails in the hospital setting resulting in injury to a patient.

An Arizona hospital stabilized an emergency room patient and instead of operating, transferred the patient to a public hospital for surgery. The reason for the transfer was because the patient did not satisfy the hospital's financial requirements for admission. The Arizona Supreme Court held that licensed hospitals were required to accept and render emergency care to all patients who presented in need of such care. The court held that the hospital could not transfer the patient until all medically indicated emergency procedures were completed without consideration of the economic consequences.

Hospitals are now taking a close look at the safety of their parking lots. They are being sued by employees, doctors, patients and visitors not only for defective conditions such as potholes, ice and snow, etc., but also for criminal attacks outside of the hospital but on hospital premises.

Several cases litigated in 1985 in-

volved the patient's refusal to accept blood. In Washington, a Jehovah's Witness refused before a D&C to consent to any blood transfusion if the need arose. The patient signed a waiver form. The court found that this waiver form did not protect the hospital or the doctor where the plaintiff bled to death as a result of negligence during the procedure. The court found that the patient had accepted the risk of no blood, but had not accepted the risk of medical negligence. At least one state supreme court found that a competent adult patient can refuse blood even though it is life threatening. However, where the patient is unconscious courts have ordered the transfusion over the objection of the patient's family. Courts have also ordered transfusion of children over the objections of their parents.

One of the most difficult areas facing hospitals in 1985 involved acquired immunodeficiency syndrome otherwise known as AIDS. The problems facing the hospital involved the emergency room, elective admissions, employee relations, whether to require AIDS screening and if so what to do with positive results. Questions have arisen as to whether or not doctors afflicted with AIDS should be allowed to operate and whether employees with AIDS should be allowed to be involved in patient care.

The consensus seems to be that it is negligent for any blood donation center or hospital not to test blood for AIDS contamination. People who are at risk are being asked not to donate. Since the results of AIDS tests in many instances must be reported to governmental agencies, the blood centers and hospitals now need detailed consent forms from the

donors acknowledging they understand that these results will be so reported.

Psychiatrists have been held liable for injuries inflicted by one of their patients on a third person when they knew that person to be at risk. A similar concern has arisen in the AIDS situation. The question has arisen whether or not there is a duty to warn others who might be at risk from the patient's AIDS condition especially where the patient is a sexually active person. For instance, must the spouse be warned.

AIDS concerns have arisen with the sperm banks. Patients are presenting in hospitals wanting volunteer blood and asking not to be transfused from the general pool. Hospitals which are self insuring all or a portion of their employees' health plan costs are faced with difficult decisions on what screening must be done since the average cost to treat an AIDS patient in 1985 has risen to \$142,000. Doctors and hospitals are faced with being sued a substantial number of years in the future in AIDS related cases because of the long incubation period and the fact that the statute of limitation runs two years from the date of discovery.

At least one case arose in which a hospital nurse sued the admitting physician for not warning her and other nurses that the patient was an AIDS victim. The nurse inadvertently broke the skin on her hand with a needle after giving an injection to the patient.

The hospitals continue to be plagued by lawsuits arising out of the granting or denying of staff privileges. One supreme court held that a hospital may deny staff

privileges. One supreme court held that a hospital may deny staff privileges solely based upon the physician's inability to work with other physicians on the staff. Another supreme court continued the trend of holding that a hospital may revoke staff privileges or deny them for the failure to maintain liability insurance.

California held there was no duty by a proctor to a patient. The proctor was asked by the hospital to oversee the operation by a surgeon who was applying for staff privileges. In the course of that operation the surgeon made an error. The patient sued the surgeon and the proctor alleging that the proctor had an obligation to step in. The court found that the proctor owed no duty to the patient.

Lawsuits involving informed consent continued to make new law. Surgeons continued to be sued for failure to advise their patients of alternatives to surgery. The courts are holding that all major schools of thought need to be conveyed to the patient, not just those that the doctors believe to be the preferred school of thought. In California, a neurologist withheld the correct diagnosis from the patient. The testimony at trial was that it was the community standard to withhold diagnoses when in the clinical judgment of the physician it was necessary. There was no medical testimony to the contrary. The judge instructed the jury that the doctor had a fiduciary obligation to the patient to disclose all risks associated with medical treatment, including all material facts known to the physician regarding the patient's condition and diagnosis. The North Carolina Supreme Court reinforced this by stating that the informed consent requirement supercedes the "best interest rule." The North Carolina Supreme Court

ruled that a physician may have to disclose risks even if he determines disclosure is not in the patient's best interest.

Four states have recently ruled on the issue of emotional distress claims associated with medical malpractice incidents. Only Michigan has allowed these claims. The Michigan court allowed parents to sue for emotional distress arising from circumstances surrounding a still birth.

One physician was held liable for the failure to warn of the possibility of hemophilia prior to birth. The physician did not cause the condition but was sued for the additional medical costs involved in raising the child. The parents claimed they would have aborted the pregnancy had they had the information concerning the possible hemophilia. Illinois rejected the attempt to make a pharmacist liable for not warning the patient that the physician was overprescribing medication. A physician was found liable to the patient's heirs for wrongfully prescribing medication in excessive amounts when the patient was a known drug addict. The patient later committed suicide. Doctors are regularly being sued at the present time for failing to obtain an informed consent before prescribing medication.

In Michigan a doctor was held liable for the injuries sustained by a person in an automobile accident where the driver, an epileptic, was a patient of the physician. The plaintiff claimed that the doctor was negligent in failing to instruct the epileptic to either continue his medication or not to drive after withdrawing from the medication. In New York the court ruled as a matter of law that the prescription of a drug by a physician in an amount ex-

ceeding the dosage recommended by the manufacturer constituted evidence of a deviation from the proper standard of medical care.

In California the court resurrected the captain of the ship doctrine to hold the surgeon liable for the actions of a nurse employed by the hospital. The court held that the nurse was acting under the direction of the doctor at the time of the incident. Several doctors were sued for revealing the identity of mothers who gave up children for adoption. These claims involved a breach of confidentiality. A national jury verdict survey has shown that while plaintiffs recover a favorable jury verdict in only 29% of their cases against general surgeons, they obtain favorable recoveries in 45% of the cases against orthopedic surgeons.

Alaskans did not escape the national trends in 1985. Reported medical malpractice claims nearly doubled in 1985. The nationwide reluctance of reinsurers to get involved in the malpractice market resulted in increased rates and decreased policy limits for many Alaska physicians.

The Alaska Supreme Court ruled in 1985 that plaintiffs may begin discovery in malpractice cases prior to the report of the medical advisory panel even though the statute itself states that discovery must generally await the report of the panel. The court held that plaintiffs would generally be prejudiced if they were required to wait until the panel had issued its report unless the panel report is filed within eighty days of the date the health care provider files an answer to the complaint. In many instances the court has not even appointed a panel within eighty days.

In 1984 the Alaska Supreme court ruled that a health care provider may use a favorable expert panel report in support of a motion asking the court to dismiss the plaintiff's case before trial. Health care providers were able to successfully use that case several times in 1985 to force dismissals of malpractice actions when the plaintiff failed to come forward with expert medical testimony contradicting the panel report.

Two medical malpractice cases were tried in 1985 in the State of Alaska. One case was tried in Anchorage and another in Fairbanks. Both resulted in verdicts in favor of the health care providers. In one case, the health care provider was actually in jail at the time the case was tried.

The MICA board continue to require that all lawsuits be tried which are determined by MICA's physician consultants to be without merit. Nothing that has happened in the legal community either in Alaska, or in the United States as a whole, during the year 1985 should operate to force a change in that policy.

Roger F. Holmes is a veteran defense lawyer of 17 years in Alaska's courtrooms. Holmes specializes in trials and appeals with his partner, Burton C. Biss in the lawfirm of BISS & HOLMES, Anchorage

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Legal Article Roger F. Holmes, Esq
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**STATE OF ALASKA 1987 LEGISLATIVE SESSION
FISCAL NOTE**

REQUEST: _____

Bill Version : _____

Publish Date : _____

Revision Date: CSSB 235(HESS)
Title: Relating to the medical malpractice liability revolving loan fund.

Agency Affected: Commerce & Economic Development
BRU: Insurance

Sponsor: Kerttula
Requestor: _____

Components: Public Protection

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
PERSONAL SERVICES	0.0	0.0	0.0	0.0	0.0	0.0
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	0.0	0.0	0.0	0.0	0.0	0.0
SUPPLIES	0.0	0.0	0.0	0.0	0.0	0.0
EQUIPMENT	0.0	0.0	0.0	0.0	0.0	0.0
LAND & STRUCTURES	0.0	0.0	0.0	0.0	0.0	0.0
GRANTS, CLAIMS	171.0	306.0	282.0	258.0	234.0	210.0
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	171.0	306.0	282.0	258.0	234.0	210.0
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE	0.0	0.0	0.0	0.0	0.0	0.0

FUNDING: (Thousands of Dollars)

GENERAL FUND	171.0	306.0	282.0	258.0	234.0	210.0
FEDERAL FUNDS	0.0	0.0	0.0	0.0	0.0	0.0
OTHER	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL	171.0	306.0	282.0	258.0	234.0	210.0

POSITIONS:

FULL-TIME	0.0	0.0	0.0	0.0	0.0	0.0
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary)

The figures above represent the total interest income on all loans made to the Medical Indemnity Corporation of Alaska to date.

Prepared by: John L. George, Director
Division: Division of Insurance

Phone: 465-2515
Date: April 28, 1987

Approved by Commissioner: J. Anthony Smith
Agency: Commerce and Economic Development

Date: April 28, 1987

Distribution (by preparer):

Legislative Finance
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Senate Secretary

MICA Medical Indemnity
Corporation of Alaska

ALASKA U.S.A. OFFICE BUILDING
4000 CREDIT UNION DR., SUITE 525
ANCHORAGE, ALASKA 99503
TELEPHONE (907) 563-3414

MEMORANDUM

TO: Bill Brock
FROM: Janet Johnston *Just*
DATE: February 9, 1987

I am responding to your request for information on settlements or verdicts involving both a physician and a hospital defendant. The information is really rather sparse.

CASE:	PAYMENT:	DISPOSITION:
1.	Hospital - \$150,000 M.D. - \$150,000	Settlement
2.	Hospital - \$ 30,000 M.D. - \$170,000	Settlement
3.	Hospital - 0 M.D. #1 - \$ 45,000 M.D. #2 - \$100,000	Settlement
4.	Hospital - \$ 7,750 M.D. #1 - 0 M.D. #2 - 0	Settlement

COMMENTS: This was strictly a nuisance value settlement which was attributed to the hospital policy by mutual agreement of the defendants. I would not suggest considering this as part of the relevant sample.

5.	Hospital - \$200,000 M.D. - 50,000	Settlement
----	---------------------------------------	------------

COMMENTS: Reflects our assessment that this case was primarily a result of nursing error.

6.	Hospital - \$1,400,000 M.D. - 550,000	Settlement
----	--	------------

Memorandum
February 9, 1987
Page Two

COMMENTS: The physician in this case was insured by MICA and we paid policy limits. The hospital, not a MICA insured, provided a structured settlement that reportedly had a cost value to the hospital of \$1,400,000 but provided benefits to the plaintiff far in excess of that amount. Had the physician had higher policy limits the hospital would not have paid as much. The hospital ended up being the "deep pocket" in a very bad case where the physician did not have adequate limits of coverage.

In addition to those cases listed above, MICA has several claims and suits that involve a MICA insured hospital and one or more MICA insured physicians that have been dropped or taken to trial with a defense verdict. I did not include these since there was no indemnity paid on them.

Another interesting situation that might have some lessons to learn stems from the fact that MICA insures several hospitals where the entire medical staff is included on the hospital policy since the physicians are employees of the hospital. Specifically we have had cases in both Dillingham and Nome where indemnity has been paid under the hospital policy for actions of the physician. Had the physician and hospital been insured under separate policies in these instances, I suspect that the hospital would have been a named defendant as well as the physician because the care rendered involved a patient in the hospital. In most, if not all, of those cases, however, it was the care of the physician that was in question.

Let me point out that in cases 1, 2, 3 and 5 listed above the amount paid for the physician as opposed to the hospital in settlement was a matter of judgment on behalf of the MICA claims staff and claims committee. The allocation to hospital versus physician reflected our judgement as to the relative apportionment of responsibility between the parties. In each of these cases, however, there was a suit involved. Had the case not ended in settlement but gone on to trial I have every reason to believe that jury would have found the physician and hospital defendants pretty much equally liable. Why? Even in a case where the physician defendant admits liability (as was the fact in one of the cases cited above) the argument can be made that professional nursing personnel within the hospital setting had an obligation to do something about it. In fact, the more egregious and indefensible the physician behavior is, the greater

Memorandum
February 9, 1987
Page Three

the obligation on a professional nurse to implement existing hospital systems to circumvent a nonresponsive or inappropriately responsive physician. Most claims against physicians occur over care that is rendered to patients in hospitals. Care that is rendered to patients in hospitals does not occur in a vacuum and, normally, there are other professional people involved in the care who should provide a system of checks and balances and who will be held liable in the event that they do not.

One final case of interest should be mentioned. It involves the largest settlement that MICA has ever made on behalf of a hospital (\$750,000). This lawsuit was brought entirely against the hospital and no physician was named as a defendant. In my opinion, physicians involved in the patient's care should have been named as defendants and should have shared in the settlement or judgment. I think jousting on the part of the involved physicians against the hospital caused the family of the deceased to sue only the hospital. I would expect that in a new era where uninsured physician have a vested interest in having the hospital held significantly liable for a bad outcome, there might be more of this kind of behavior.

I hope the above information is of some assistance to you. As I mentioned, there have not been any cases decided under the new joint and several law and the law, as previously constructed, did not cause anyone to ask juries to apportion percentage responsibility between physicians and hospitals.

/jk

MEDICAL INDEMNITY CORPORATION OF ALASKA (MICA)

A brief history and description.
Prepared by Rep. John Sund's office;
Revised March 16, 1987

CREATION

MICA is an insurance company created by the Alaska Legislature to provide professional liability insurance to Alaskan physicians and surgeons, hospitals and related health care organizations. The company was established in response to the lack of available malpractice insurance in the state in the mid-1970s. MICA commenced business on June 28, 1976.

STRUCTURE

MICA is administered by a nine-member board appointed by the governor and confirmed by the Legislature. The board consists of four physicians, a hospital administrator, two insurance industry professionals and two persons unrelated to the health care and insurance industries. The board maintains a plan of operation, which is subject to approval by the state director of the Division of Insurance.

The Legislature deliberately set up MICA to be a free-standing corporation with no direct political involvement in its operations. MICA reports to the Division of Insurance in the same manner as all insurance companies operating in the state. However, unlike other insurance companies, the Division of Insurance does have an extended relationship with MICA through approval of the plan of operation and capitalization loans (explained below). The Division is also invited to all MICA board meetings, but does not vote.

MICA is based in Anchorage. The daily operations are managed by the brokerage firm Marsh & McLennan. But the MICA board is moving toward self-management. MICA's actuary is Milliman & Robertson.

The state ruled that MICA is exempt from income taxes. That has not, to date, been challenged by the IRS.

By statute, MICA may be terminated by the director of the Division of Insurance if it posts written premiums for two consecutive years of less than 35 percent of all premiums written in the state for physicians' medical malpractice insurance, or posts premiums for one calendar year of less than 20 percent of all malpractice premiums in the state. The decision to terminate would be made by the director of insurance following public hearings.

CAPITALIZATION

The Legislature established in the Department of Commerce and Economic Development a medical malpractice liability revolving loan fund to capitalize MICA. The fund is administered by the director of insurance. The original loan was \$3 million, payable at 7 percent interest. MICA is paying interest, but there is no due date on the principal and the state loan is subordinate to all other obligations of the corporation. MICA must make a loan repayment in the event of an underwriting profit, but that has not happened to date. The board intends to pay off the loan in 15 years.

In 1979, the Division of Treasury purchased the \$3 million note from Commerce and Economic Development, thereby putting \$3 million more into the fund for MICA to borrow in the future. In late 1986, MICA requested an additional \$3 million loan to offset losses experienced in 1985 (see explanation below). The director of insurance approved a \$2 million loan which, by statute, is payable in five years at 6 percent interest. The fund balance is now \$1 million.

FINANCIAL STATUS

Due largely to a reinsurance problem (explained below), MICA posted a \$2.14 million loss in 1985. The company used its entire \$2 million surplus built up in prior years to offset the loss. (Hence the reason for the loan request in 1986.) MICA's assets totaled \$10.47 million at the end of 1985 with \$6.5 million in reserve for claim payments.

REINSURANCE PROBLEM OF 1985

In late 1984, after MICA had set its policy rates for 1985, the company faced a problem with its reinsurers which led to a financial loss. One of the company's reinsurers denied renewal of MICA's policy while another approximately tripled its premium rate. Not only did the reinsurance cost increase, the coverage diminished, leaving MICA with greater personal risk in claim settlements. Because of the late notice on the reinsurance rates, MICA could not reflect the increase in its premium rates. Thus, 1985 posted a large loss. MICA also had a couple of large claims in 1985 which the reinsurand did not fully cover, adding to MICA's dip into its surplus. MICA obtained better reinsurance in 1986 and for 1987, but the company also has to recoup some of the 1985 losses. As a result, and as a reflection of malpractice insurance in general, MICA's policy rates increased as much as 90 percent from 1985 to 1986.

PRESENT SITUATION WITH HOSPITALS

MICA recently established a new policy requiring that all physicians in MICA-covered hospitals carry \$500,000 liability insurance. Meeting that requirement is causing financial difficulties for at least 7 of the 12 hospitals insured by MICA in 1986:

Wrangell
Cordova
Homer
Petersburg
Seward
Sitka
Palmer

Because of the hardship to the hospitals, MICA then agreed to establish a separate, and higher rate for those hospitals whose physicians are not carrying at least \$500,000 malpractice insurance.

As of this writing, MICA is in the process of setting the new rates and it appears the added cost to the hospitals will be approximately 25 percent of what the physicians' premium would have been. (For example, if the hospital had two doctors without insurance and their insurance would have cost \$20,000 each, the added premium cost to the hospital would be \$10,000.)

Addendum: According to MICA, most claims against hospitals involve doctors and 85.4 percent of MICA's pending claims include hospitals.

MICA Premiums for Wrangell General Hospital

	<u>1985</u>	<u>1986</u>	<u>1987</u>
MICA	\$17,900*	\$58,000*	\$54,000**
Hospital Budget	\$1.9 mill	\$2.0 mill	\$2.0 mill
MICA % of Total Budget	.94%	2.9%	2.7%

*Coverage in 1985 was \$1 million maximum per occurrence and \$2 million aggregate. Coverage in 1986 and 1987 dropped to \$500,000 per occurrence and \$1 million aggregate.

**Wrangell Hospital's premium rate for 1987 was first quoted at \$81,000 (in January of this year.) MICA just revised the rate to \$54,000. But that rate does not include any surcharge for having a physician in the hospital who does not have medical malpractice insurance. Wrangell has one physician without coverage.

MEDICAL INDEMNITY CORPORATION OF ALASKA

PREMIUMS EARNED AND CLAIMS ANALYSIS (GROSS OF REINSURANCE)

	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	TOTAL
.....												
PREMIUMS:												
PREMIUMS WRITTEN	\$372,404	\$800,969	\$1,050,303	\$1,341,111	\$1,243,110	\$1,804,334	\$1,951,954	\$2,007,096	\$2,775,055	\$2,921,005	\$5,926,076	\$22,281,5
LESS REINSURANCE CEDED				4627,328	\$293,753	4799,641	\$754,338	\$804,167	\$1,119,692	\$897,183	\$1,045,000	\$6,341,1
PREMIUMS EARNED	\$372,404	\$800,969	\$1,050,303	\$713,783	\$949,357	\$1,004,693	\$1,197,616	\$1,202,929	\$1,655,363	\$2,023,822	\$4,881,076	\$15,940,4
.....												
CLOSED CLAIMS:												
LOSS AND LOSS ADJUSTMENT EXPENSE PAID	\$0	\$407,670	\$392,441	\$82,701	\$669,012	\$335,563	\$1,211,946	\$2,369,918	\$1,294,231	\$1,017,591	\$36,960	\$7,800,0
NUMBER OF CLOSED CLAIMS	0	9	11	5	16	16	20	22	27	24	7	1
AVERAGE SEVERITY CLOSED CLAIMS	\$0	\$45,297	\$35,676	\$16,540	\$41,863	\$20,973	\$60,597	\$107,724	\$47,564	\$42,400	\$5,200	\$49,7
.....												
OPEN CLAIMS:												
RESERVES 12/31/86								\$13,619	\$4,726,517	\$6,505,452	\$3,377,640	\$14,701,2
PAYMENTS THRU 12/31/86								\$80,955	\$955,939	\$99,855	\$159,225	\$1,245,9
INCURRED OPEN CLAIMS								\$94,574	\$5,682,456	\$6,605,307	\$3,536,865	\$15,999,2
NUMBER OF OPEN CLAIMS								3	14	26	24	7
AVERAGE SEVERITY OPEN CLAIMS								\$31,525	\$405,890	\$257,127	\$147,369	\$230,7
.....												
TOTAL OPEN AND CLOSED CLAIMS:												
TOTAL PAID AND RESERVED (INCURRED)	\$0	\$407,670	\$392,441	\$82,701	\$669,012	\$335,563	\$1,211,946	\$2,464,492	\$6,966,687	\$7,702,890	\$1,573,025	\$23,000,0
TOTAL CLAIMS	0	9	11	5	16	16	20	25	41	50	31	7
AVERAGE SEVERITY ALL CLAIMS	\$0	\$45,297	\$35,676	\$16,540	\$41,863	\$20,973	\$60,597	\$90,580	\$169,919	\$154,058	\$115,205	\$106,2

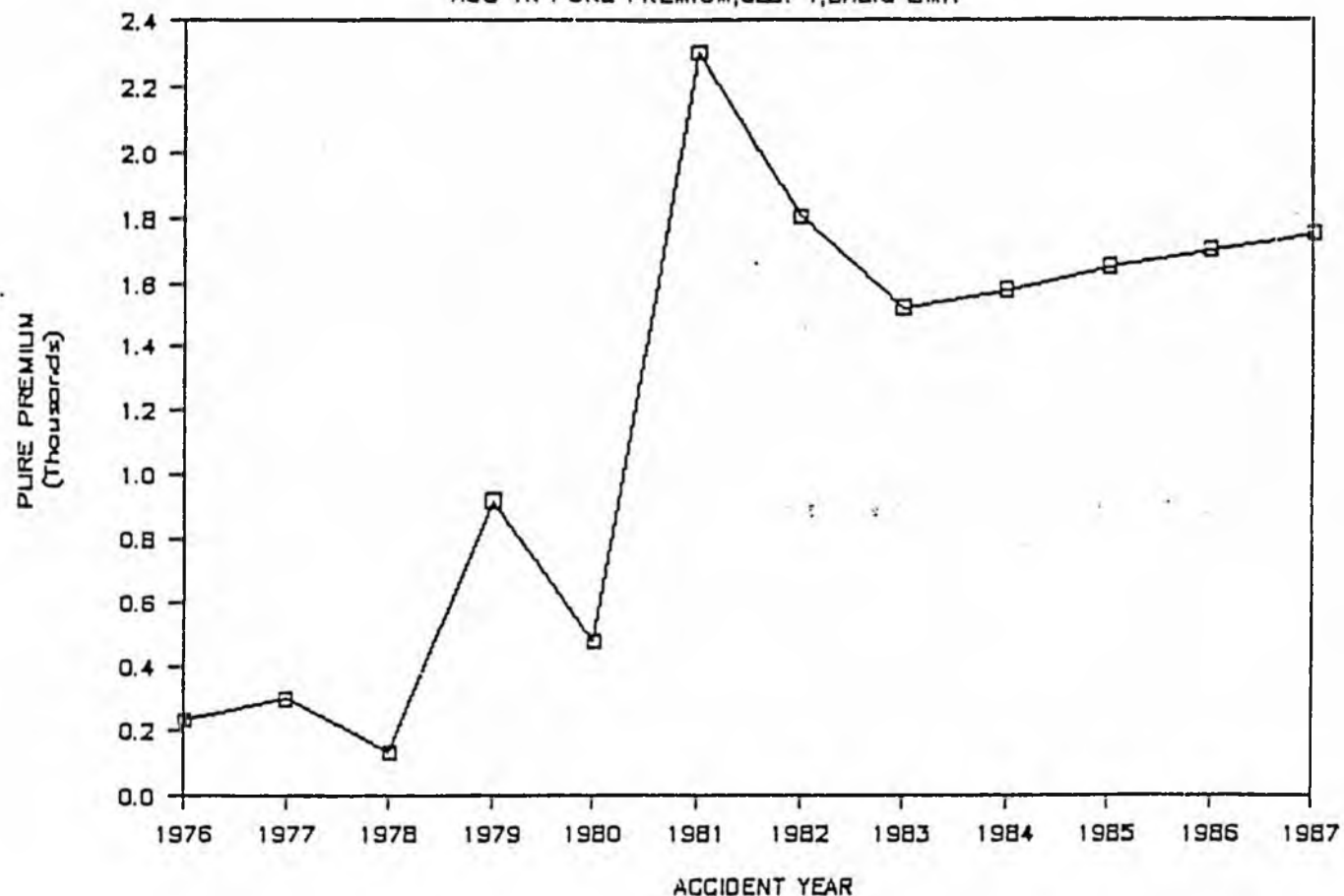
MEDICAL INDEMNITY CORPORATION OF ALASKA

PREMIUMS EARNED AND CLAIMS ANALYSIS (NET OF REINSURANCE)

	1976	1977	1978	1979	1980	1981	1982	1983	1984	1985	1986	TOTAL
PREMIUMS EARNED	\$372,404	\$400,969	\$1,050,383	\$713,783	\$949,357	\$1,004,693	\$1,197,616	\$1,202,929	\$1,655,363	\$2,023	\$4,001,076	\$15,940,4
CLOSED CLAIMS:												
NET LOSS AND LOSS ADJUSTMENT EXPENSE PAID	\$0	\$407,670	\$381,470	\$82,701	\$564,544	\$335,563	\$1,170,585	\$1,270,609	\$837,668	\$922,906	\$16,940	\$6,010,7
NUMBER OF CLOSED CLAIMS	0	9	11	5	16	16	20	22	27	24	7	1
AVERAGE SEVERITY CLOSED CLAIMS	\$0	\$45,297	\$34,679	\$16,540	\$35,284	\$20,973	\$58,529	\$57,755	\$31,025	\$38,458	\$5,200	\$38,2
OPEN CLAIMS:												
RESERVES 12/31/86								\$13,619	\$1,391,517	\$3,771,753	\$3,307,640	\$8,484,5
PAYMENTS THRU 12/31/86								\$80,955	\$955,939	\$99,855	\$159,225	\$1,245,0
INCURRED OPEN CLAIMS								\$91,574	\$2,347,456	\$3,871,608	\$3,466,065	\$9,700,5
NUMBER OF OPEN CLAIMS								3	14	26	24	1
AVERAGE SEVERITY OPEN CLAIMS								\$31,525	\$167,675	\$148,903	\$144,453	\$145,9.
TOTAL OPEN AND CLOSED CLAIMS:												
TOTAL PAID AND RESERVED (INCURRED)	\$0	\$407,670	\$381,470	\$82,701	\$564,544	\$335,563	\$1,170,585	\$1,365,183	\$3,105,124	\$4,794,594	\$3,503,825	\$15,791,2
TOTAL CLAIMS	0	9	11	5	16	16	20	25	41	50	31	2.
AVERAGE SEVERITY ALL CLAIMS	\$0	\$45,297	\$34,679	\$16,540	\$35,284	\$20,973	\$58,529	\$54,607	\$77,686	\$95,892	\$113,027	\$70,4

MICA HOSPITALS

ACC YR PURE PREMIUM,CLS. 1,BASIC LIMIT



MICA Medical Indemnity
Corporation of Alaska

ALASKA U.S.A. OFFICE BUILDING
4000 CREDIT UNION DR., SUITE 525
ANCHORAGE, ALASKA 99503
TELEPHONE (907) 563-3414

MICA POLICYHOLDER PROFILE

<u>YEAR ENDING</u>	<u>PHYSICIANS</u>	<u>HOSPITALS</u>	<u>RELATED HEALTH CARE</u>
12-31-86	336	11	14
12-31-85	364	12	12
12-31-84	300	12	10
12-31-83	213	12	11
12-31-82	200	13	12
12-31-81	161	13	9
12-31-80	138	13	9
12-31-79	104	13	2

MICA PHYSICIANS AND SURGEONS

ACC YR PURE PREMIUM, CLS. 1, BASIC LIMIT

