SB
235

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION: CSSB 235(HESS)
PUBLISH DATE: 04/07/87

FISCAL NOTE

REQUEST:

Revision Date: 04/29/87
Title: Relating to medical malpractice liability revolving loan fund
Sponsor: CS by S HESS
Requester:

Agency Affected: Commerce & Economic Dev.
BRU: Insurance
Components: Public Protection

EXPENDITURES / REVENUES : (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
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	153.0	282.0	258.0	234.0	210.0	186.0
MISCELLANEOUS	0.0	0.0	0.0	0.0	0.0	0.0
TOTAL OPERATING	153.0	282.0	258.0	234.0	210.0	186.0

	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0

	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
REVENUE	0.0	0.0	0.0	0.0	0.0	0.0

FUNDING: (Thousands of dollars)

	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
GENERAL FUND	153.0	282.0	258.0	234.0	210.0	186.0
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	153.0	282.0	258.0	234.0	210.0	186.0

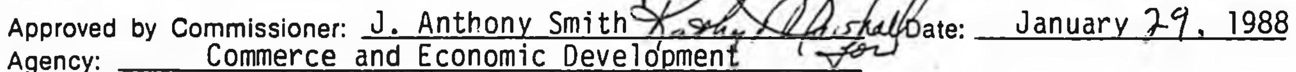
POSITIONS:

	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
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: January 29, 1988



Approved by Commissioner: J. Anthony Smith
Agency: Commerce and Economic Development
Date: January 29, 1988

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

DK/dg10643K
012788a

No. 300

STATE OF ALASKA 1987 LEGISLATIVE SESSION
FISCAL NOTE

SENATE
BILL VERSION: CSSB 235(HESS)
PUBLISH DATE: 4/28/87

REQUEST:

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

Agency Affected: Commerce & Economic Development
BRU: Insurance
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)

	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
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:

	FY 87	FY 88	FY 89	FY 90	FY 91	FY 92
FULL-TIME	0.0	0.0	0.0	0.0	0.0	0.0
PART-TIME						
TEMPORARY						

ANALYSIS:

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
- Legislative Sponsor
- Requestor
- Office of Management and Budget
- Impacted Agency(ies)
- Senate Secretary

0496K

Alaska State Legislature

Senate

Official Business

P.O. BOX V
State Capitol
Juneau, Alaska 99811

April 30, 1987

Senator Tim Kelly
Chair, Senate Labor and Commerce
Box V
Juneau, Alaska 99811

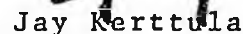
Dear Senator Kelly,

I would appreciate your scheduling SB-235, relating to the Medical Liability Revolving Loan Fund, as soon as possible. SB-235 will help our small hospitals by allowing them to apply for state grant money to pay for their liability insurance. The money would come from the interest that the Medical Insurance Company of Alaska is paying on their state loans.

$300,000.00 will become immediately available to aid small hospitals pay for their insurance if SB-235 passes this session. Because MICA is required by law to continue paying off its loan, including part of the principal each year, this amount will be reduced by $24,000. next year.

A packet of information concerning the bill is included. Thank you for considering SB-235. I believe this bill is a positive step toward solving the insurance crisis in Alaska.

Sincerely,



Jay Kerttula

JK/bk
enc.

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 reinsurance 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

	1985	1986	1987
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	$808,969	$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,[illegible]81,5
LESS REINSURANCE CEDED				$627,328	$293,753	$799,641	$754,338	$804,167	$1,119,692	$897,183	$1,045,000	$6,341,1
PREMIUMS EARNED	$372,404	$808,969	$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	$1,284,231	$1,017,591	$36,400	$7,808,0
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	$41,813	$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	$1,377,640	$14,701,2
PAYMENTS THRU 12/31/86								$80,955	$955,939	$99,855	$159,225	$1,295,9
INCURRED OPEN CLAIMS								$94,574	$5,682,456	$6,605,307	$1,536,865	$15,999,2
NUMBER OF OPEN CLAIMS								3	14	26	24	[illegible]
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	$7,702,898	$1,573,825	$21,808,0
TOTAL CLAIMS	0	9	11	5	16	16	20	25	41	50	31	2[illegible]
AVERAGE SEVERITY ALL CLAIMS	$0	$45,297	$35,676	$16,540	$41,813	$20,973	$60,597	$98,580	$169,919	$154,058	$115,285	$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	$372,444	$888,969	$1,050,383	$713,783	$949,357	$1,004,693	$1,197,616	$1,202,929	$1,655,363	$2,023,022	$4,881,076	$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	$922,986	$36,960	$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	$5,280	$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	$158,425	$1,295,0
INCURRED OPEN CLAIMS	---------	---------	---------	---------	---------	---------	---------	$94,574	$2,347,456	$3,871,608	$3,466,065	$9,780,5
NUMBER OF OPEN CLAIMS								3	14	26	24	[illegible]
AVERAGE SEVERITY OPEN CLAIMS								$31,525	$167,675	$148,908	$144,419	$185,9
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	$3,185,124	$4,794,594	$3,503,025	$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 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

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.

CASE:	PAYMENT:	DISPOSITION:
5.	Hospital - $200,000 M.D. - 50,000	Settlement

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

CASE:	PAYMENT:	DISPOSITION:
6.	Hospital - $1,400,000 M.D. - 550,000	Settlement

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.

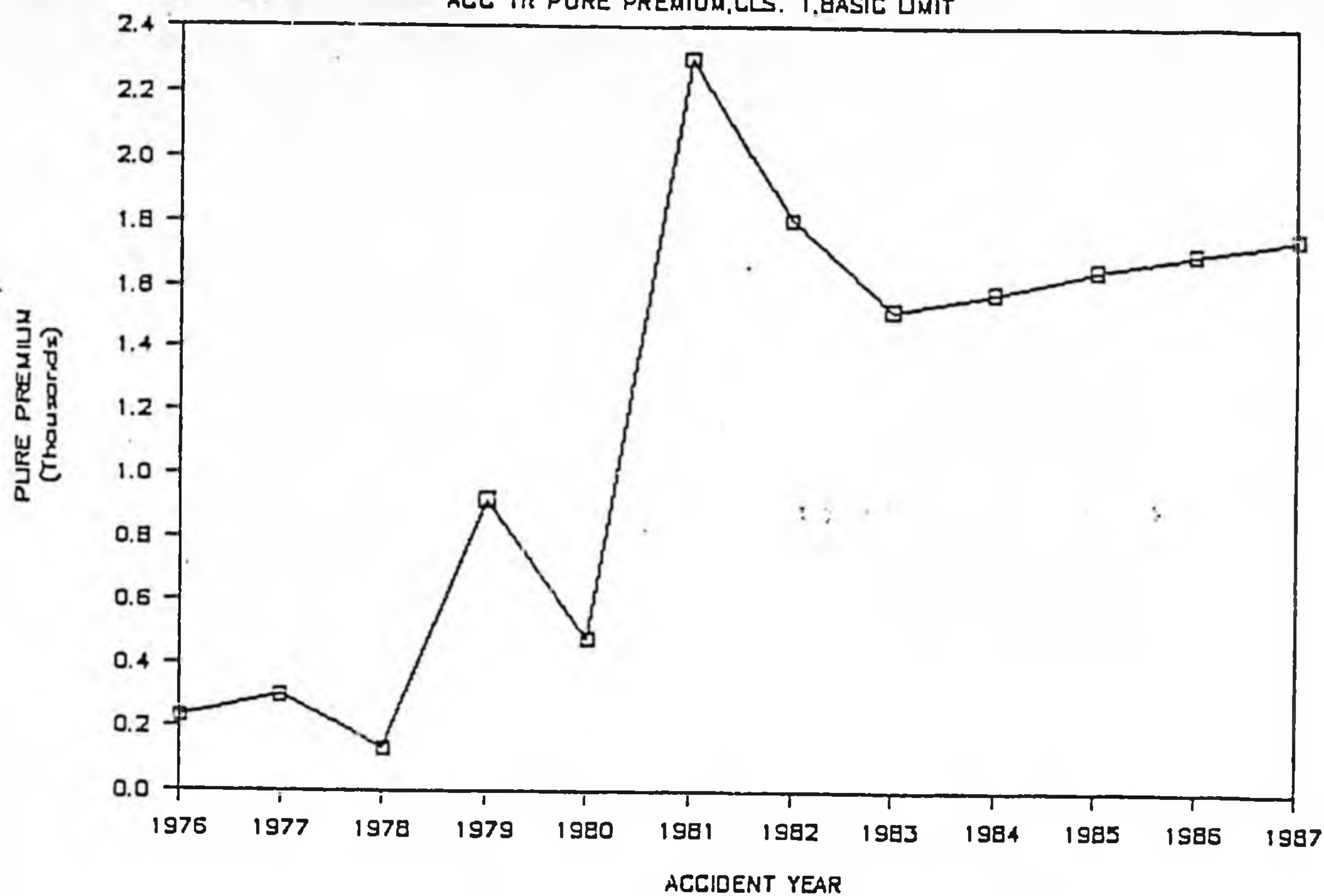
Let me point out that in cases 1, 2, 3 and 5 listed above the amount paid for the physician as opposed to the hospital in settlement was a matter of judgment on behalf of the MICA claims staff and claims committee. The allocation to hospital versus physician reflected our judgement as to the relative 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 egre-giouss and indefensible the physician behavior is, the greater

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

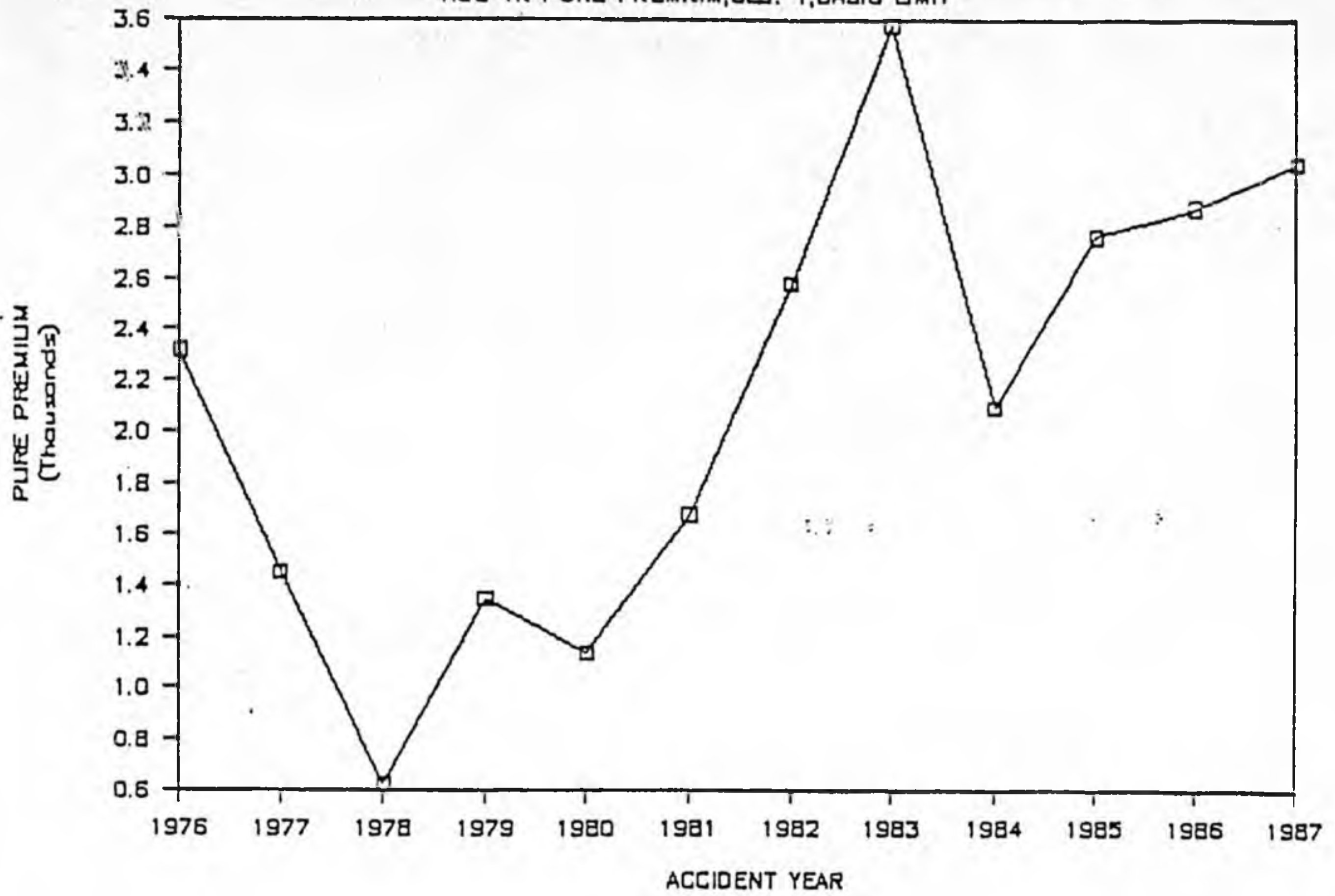

MICA HOSPITALS
ACC YR PURE PREMIUM,CLS. 1,BASIC LIMIT
PURE PREMIUM
(Thousands)
2.4
2.2
2.0
1.8
1.6
1.4
1.2
1.0
0.8
0.6
0.4
0.2
0.0
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
ACCIDENT YEAR

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

YEAR ENDING	PHYSICIANS	HOSPITALS	RELATED HEALTH CARE
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
PURE PREMIUM
(Thousands)
3.6
3.4
3.2
3.0
2.8
2.6
2.4
2.2
2.0
1.8
1.6
1.4
1.2
1.0
0.8
0.6
1976
1977
1978
1979
1980
1981
1982
1983
1984
1985
1986
1987
ACCIDENT YEAR

(1) AS 21.03
(2) AS 21.06
(3) AS 21.09, excep' \S 21.09.090
(4) AS 21.18.010
(5) AS 21.18.030
(6) AS 21.18.040
(7) AS 21.18.120
(8) AS 21.21.321
(9) AS 21.36
(10) AS 21.69.400
(11) AS 21.69.520
(12) AS 21.69.600, 69.620, and 21.69.630
(13) AS 21.78
(14) AS 21.90
(15) AS 21.42.345 a d 21.42.355
(16) AS 21.89.040
(17) AS 21.89.060. (1 ch 120 SLA 1966; am § 1 ch 92 SLA 1974; am § 2 ch 95 SLA 197 ; am § 2 ch 84 SLA 1976; am § 24 ch 40 SLA 1981; am § 3 ch 45 S \ 1981)

Effect of amendments - The first 1981 amendment adde "and AS 21.42.355" in paragraph (1! The second 1981 amendment added paragraph (17).

Sec. 21.87.350. Ex ting certificates of authority. A health care service contractor rep 'ered to do business in this state on July 1, 1966, is entitled to be gistered under this chapter, whether or not it meets the requiremen of this chapter. (§ 1 ch 120 SLA 1966)

Chapter 88. H alth Care Providers Insurance.

Article
1. Purpose (§ 21.88.010)
2. Medical Indemnity Corp ation of Alaska (§§ 21.88.020 — 21.88.095)
3. Loan Fund (§ 21.88.210)
4. General Provisions (§ 21 3.900)

Cross references. — Fo severability provisions of 1976 Act, see 48, ch. 102, SLA 1976, in the Temporar and Special Acts; for purpose of 1978 am latory Act, see § 1, ch. 177, SLA 1978 a amended by § 7, ch. 46, SLA 1982, in the Temporary and Special Acts; for effect of 1978 Act on certain policies, see § 21, ch 177, SLA 1978 as amended by § 8, ch. 46, SLA 1982, in the Temporary and Special Acts.

Article 1. Purpose.

Section
10. Purpose of this chapter

Sec. 21.88.010. Purpose of this chapter. It is the purpose of this chapter to provide a means of furnishing health care providers with adequate insurance against liability for medical negligence. (§ 41 ch 102 SLA 1976)

NOTES TO DECISIONS

Chapter 102, SLA 1976, enacted in violation of Alas. Const., art. II, § 14. — Where the free conference committee recommended adoption of a version of ch. 102, SLA 1976 (which, inter alia, enacted AS 21.88), that differed in many respects from the version originally passed by the house; the free conference committee's bill was passed by the senate by a recorded vote; but in the house there was no roll call or recorded vote and the free conference committee bill was passed there by a simultaneous voice vote, this voice vote constituted "final passage" of ch. 102, SLA 1976, and thus violated the recorded vote requirement of Alas. Const., art. II, § 14. Plumley v. George E. Hale, M.D., Inc., Sup., Ct. Op. No. 1847 (File Nos. 4014, 4017), 594 P.2d 497 (1979).

But this holding is to be applied prospectively. — Although the supreme court held that ch. 102, SLA 1976 (which, inter alia, enacted AS 21.88), was enacted in violation of the recorded vote requirement of Alas. Const., art. II, § 14, the supreme court held that its holding in this case should be applied prospectively in light of its conclusions that its decision was one of first impression, that substantial reliance had followed from the legislature's alternative interpretation of law, that undue hardship would have resulted from retroactive application of its holding, and that the rationale of the holding did not compel retroactivity. Plumley v. George E. Hale, M.D., Inc., Sup. Ct. Op. No. 1847 (File Nos. 4014, 4017), 594 P.2d 497 (1979).

Article 2. Medical Indemnity Corporation of Alaska.

Section
20. Corporation created
30. Corporation board of governors
40. Corporation plan of operation
50. Powers and duties of the corporation
55. Termination
60. Premium tax
70. Statistics
80. Rates
90. Payment of premiums; cancellation of insurance
95. Transfer of corporate assets and liabilities

Sec. 21.88.020. Corporation created. There is created the Medical Indemnity Corporation of Alaska which is a public corporation having a legal existence independent of and separate from the state. Obligations issued by the corporation do not constitute a debt, liability or obligation of the state or a pledge of full faith and credit of the state. (§ 41 ch 102 SLA 1976)

Sec. 21.88.030. Corporation board of governors. (a) The corporation shall exercise its powers through a board of governors which is

appointed by the govern r of the state and confirmed by the legislature. Members of the board of governors shall be Alaska residents as follows:

(1) four physicians lic nsed in the state and engaged in private practice in the state; no mo than two of the physicians shall practice or live in a municipality l ving a population of more than 100,000, and two of the physicians ist be indemnified against loss by reason of liability for an act or ission in the delivery of professional health care by the Medical In mnity Corporation of Alaska;

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

(3) two professionals from the insurance industry who are authorized or licensed to do isiness in the state;

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

(b) The term of office each governor is three years, except that the governor of the state sh l designate two initially appointed governors to serve for one year an wo initially appointed governors to serve for two years. Upon the ex ation of the term of a governor, the governor of the state shall appoi a successor who shall be from the same class described in (a) of this s ion as the governor whose term has expired.

(c) Upon a governor' arly resignation, death or inability to serve, the governor of the sta hall appoint a successor from the same class defined in (a) of this s ion as the terminating governor, who shall serve for the unexpire erm.

(d) The director or a signee of the director is not a voting member of the board of governo ut shall be notified by the board of and have the right to attend and rticipate in all meetings and proceedings of the board.

(e) Members of the b d of governors receive compensation from the corporation and nece ry travel expenses according to a policy approved by the direct

(f) A governor, offic or employee or former governor, officer, or employee of the corpor n is not liable for damages or other relief in any action by reason of e person's actions or inactions as a governor, officer, or employee of corporation, or by reason of the actions or inactions of the corp ation, its board of governors, officers or employees unless the p on acts with actual knowledge that the person was acting outside scope of the person's authority, or unless at the time the person w cting for a purpose which the person knew was not in the best int sts of the corporation, or with respect to any criminal action the pers had actual knowledge or should have known the person's action was lawful. If a claim or action is brought against a person entitled to the tection of this subsection, the claim or action shall be defended by th state. If it is established that the person was acting with actual kno ledge that the person was acting outside the scope of the person's authority, or at the time was acting for a purpose which the person knew was not in the best interests of the corporation, or with respect to any criminal action the person had actual knowledge or should have known the person's action was u lawful, then the person shall reimburse the state for the cost to the state of the person's defense. (§ 41 ch 102 SLA 1976; am §§ 4, 5 ch 177 SLA 1978; am § 2 ch 103 SLA 1980; am § 1 ch 46 SLA 1982)

Effect of amendments. — The 1980 amendment deleted "of $100 per day when the board meets" following "the corporation", and added "according to a policy approved by the director", both in subsection (e).

The 1982 amendment substituted "the insurance industry who are authorized or licensed to do business" for "insurance companies authorized" in subsection (a)(3).

Sec. 21.88.040. Corporation plan of operation. (a) Within 30 days after May 29, 1976, the board of governors shall prepare and submit to the director for approval a plan of operation which provides for the fair and reasonable administration of the affairs of the corporation and the discharge of the purposes for which it is created. The plan and any amendments to it become effective upon the director's approval. If the board of governors fails to submit a plan of operation, or if at a subsequent time the board of governors fails to submit suitable amendments to the plan, the director shall, after notice and hearing, adopt and promulgate a plan of operation or amendments which are necessary or advisable to carry out the provisions of this chapter. Adoption of the plan is not subject to the Administrative Procedure Act (AS 44.62).

(b) The plan of operation shall

(1) establish the procedures by which all the powers and duties of the corporation specified in AS 21.38.050 shall be performed;

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

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

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

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

(6) establish the procedures for issuing contracts of insurance as provided in AS 21.88.050 and for the determination of rates;

(7) contain additional provisions necessary for the execution of the powers and duties of the corporation. (§ 41 ch 102 SLA 1976)

Sec. 21.88.050. Powers and duties of the corporation. (a) The corporation shall

(1) in the form approved by the director, issue to all physicians and hospitals who are found to be acceptable risks under standards

developed under (5) of this subsection, and who pay the premiums for it, a contract or contracts indemnifying physicians and hospitals and their employees who are health care providers against loss by reason of liability for covered claims for an act or omission in the delivery of professional health care in this state, and agreeing to tender on behalf of the physicians and hospitals and their employees who are health care providers a defense to a covered claim in a proceeding brought under AS 09.55.530 — 09.55.560; the limits of liability for policies issued by the corporation shall be approved by the director; the contract shall cover the defense against but need not indemnify liability for punitive damages arising from a covered claim; at the option of the corporation, if approved by the director, and for an additional premium the contract may cover claims against the physician or hospital that arise out of professional services performed by the physician or hospital for any period before the contract is issued, except that coverage will not be provided for a claim already filed or of which the physician or hospital had or reasonably should have had notice at the time the retroactive insurance was purchased;

(2) charge a premium for the protection provided by the contracts issued by the corporation which shall be determined by the board of governors in accordance with AS 21.88.080 and subject to the approval of the director;

(3) comply with or be subject to AS 21.06.090, 21.06.120, 21.06.140, 21.06.160, 21.06.250, AS 21.09.180 — 21.09.200, 21.09.250, 21.09.280, AS 21.12.020(b)-(e), AS 21.18, AS 21.21, AS 21.24 and AS 21.36; and shall be exempt from participation as a member insurer in the Alaska Insurance Guaranty Corporation;

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

(5) establish standards for the acceptability of risks; in establishing these standards the corporation may exclude an applicant for insurance based on individual risk selection factors, but may not exclude an applicant based only on the classification of the applicant.

(b) The corporation may

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

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

(3) provide coverage to insureds for other hazards customarily included in medical malpractice insurance policies when there is a finding by the director that this coverage is not available to insureds of the Medical Indemnity Corporation of Alaska in the private insurance market at a competitive price;

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

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

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

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

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

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

(10) in a form approved by the director and for an additional premium determined under AS 21.88.080, issue endorsements which provide indemnity for claims not yet reported which arise out of professional services rendered during a period of continuous coverage under the originally issued contract, to physicians and hospitals who pay the premium for it and who are terminating their original covered claims contract with the corporation for a period of 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 the state under the supervision of a physician. (§ 41 ch 102 SLA 1976; am §§ 6 — 10, 40 ch 177 SLA 1978; am §§ 3, 4, 7 ch 103 SLA 1980; am §§ 2 — 4 ch 46 SLA 1982)

Revisor's notes. — In 1984, in subsection (a), former paragraphs (4), (5), (6), and (8) were renumbered as present paragraphs (2), (3), (4), and (5), respectively, and, in subsection (b), former paragraphs (11) and (12) were renumbered as present paragraphs (10) and (11), respectively.

Effect of amendments. — The 1980 amendment, in subsection (a), substituted "the limits of liability for policies issued by the corporation shall be approved by the director" for "the minimum limit of liability issued to physicians shall be $200,000 per occurrence and $600,000 aggregate liability per year, and the minimum limit of liability provided in contracts issued to hospitals shall be $200,000 per occurrence and an annual aggregate liability of $1,000,000 minimum plus an additional $20,000 per bed for each occupied bed over 50" near the middle of paragraph (1). The amendment, in paragraph (8) (now (5)) of subsection (a), substituted "an applicant for insurance" for "a physician", "an applicant" for "a physician", and "applicant" for "physician"; and repealed former paragraph (10) of subsection (b) (since deleted).

The 1982 amendment, in paragraph (1) of subsection (a), substituted "corporation, if approved by the director" for "physician or hospital" and substituted "before the contract is issued" for "after December 31, 1974, if the coverage is issued before January 1, 1977." The amendment also rewrote paragraphs (3) and (12) (now (11)) of subsection (b).

Sec. 21.88.055. Termination. (a) If at any time the corporation posts written premiums for two consecutive years of less than 35 per cent of all premiums written in Alaska for physicians' medical malpractice insurance or posts written premiums for one calendar year of less than 20 per cent of all premiums written in Alaska for physicians'

medical malpractice, the director may hold a public hearing in accordance with AS 21.06.180 — 21.06.230 to determine whether the business of the corporation should be terminated.

(b) Upon the effective date of an order of termination issued by the director under (a) and (d) of this section, the terms of the governors appointed under AS 21.88.030 expire, and the corporation, its governors, officers and employees are relieved of all further liabilities for all their obligations to the creditors and policyholders of the corporation, and the business of the corporation shall be liquidated according to AS 21.78.

(c) At any time after termination of the corporation by the director, the director may, after public hearing held in accordance with AS 21.06.180 — 21.06.230 and (d) of this section, order reactivation of the corporation if the director finds that malpractice insurance is unavailable for physicians and hospitals on the voluntary market. The business of the corporation shall commence operation upon appointment by the governor of new governors to the board.

(d) In determining whether to terminate or reactivate the business of the corporation the director shall consider the following:

(1) the level of expected premiums and losses for continued operation;

(2) the requirement for state funds to support continued operation;

(3) the availability of alternative markets for coverage to a substantial majority of physicians and hospitals in the state;

(4) the costs of continued operation of the corporation;

(5) the impact that the continued operation of the corporation will have on rates charged for coverage by the corporation or by alternative markets; or

(6) the expected number of physicians or hospitals who would participate if the operations were continued.

(e) If after public hearing held in accordance with (a) and (c) of this section the director determines that continuing the business of the corporation would result in substantial underwriting loss unless excessive premiums are charged to participating physicians and hospitals, the director may order termination of the corporation. (§ 11 ch 177 SLA 1978)

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

(b) The corporation is exempt from taxation under this section for a period of five years starting from July 1, 1978. (§ 41 ch 102 SLA 1976; am § 12 ch 177 SLA 1978)

Sec. 21.88.070. Statistics. The corporation shall collect, maintain and report information concerning claims against health care providers which it insures. The information shall be on forms prescribed by the director, and shall be sufficient to enable a proper determination of losses for rate making and to identify causes and sources of loss for loss control. At least annually the corporation shall report to the director the number and amount of claims filed, reserved, paid, settled and adjudicated during the year, the premiums paid to and the expenses incurred by the corporation during the year. This report shall be available to the public. The director may require that supplemental reports include the names of insured health care providers and the claimants; however, a report that becomes available to the public may not include the names of health care providers or claimants or information that will permit by inference the identity of specific health care providers or claimants. All statistics including the supplemental reports shall be made available to the State Medical Board. (§ 41 ch 102 SLA 1976; am § 14 ch 177 SLA 1978)

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

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

(2) rates may not be excessive; rates are excessive if, after a period of time and with respect to an amount of gross premium which is actuarially credible, the premiums exceed losses incurred by the corporation, including losses paid, reserves for covered claims reported and unpaid, reserves for covered claims incurred during the policy period and not reported, and reasonable expenses for the operation of the corporation;

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

(4) rates may not be unfairly discriminatory;

(5) rates shall be adjusted annually;

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

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

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

(9) individual risk underwriting factors shall be considered;

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

(11) amounts sufficient for repayment of loan obligations shall be considered;

(12) if the earned premiums of the corporation for any given year are less than the incurred claims, claim expense, underwriting expense, reserves for that year and provision for repayment of any loans, the corporation may, subject to the prior approval of the director, levy an assessment upon the insureds who held policies during that year; the assessment, which may be made in periodic installments, shall be made within three years and may not exceed 150 per cent of the insured's premium for that year; the termination of any policy does not relieve the insured of contingent liability for the insured's proportionate share of the obligations to the corporation which accrued while the policy was in force;

(13) if the earned premiums of the corporation for any given year exceed its incurred claim expense, underwriting expense, reserves for that year and provision for repayment of any loan, the corporation may, subject to the prior approval of the director, apportion and pay or credit its insureds who held policies during that year; a payment or credit shall be proportionate to the insured's earned premium for that year;

(14) upon application by any person, the director may issue a certificate authorizing the corporation to extinguish all or a portion of an assessment levied, or which could be levied, under (12) of this section for all insureds with policies in force when the certificate is issued, and to omit provisions levying an assessment under (12) of this section in all policies delivered or issued for delivery after the certificate is issued, if the director determines that there is a sound actuarial basis for the extinguishment; the director may at any time revoke the certificate; a policy in force at the time of revocation is not subject to the revocation of the certificate for the remainder of the period for which the premium has been paid, but after revocation a policy may not be issued or renewed without providing for an assessment of the insured. (§ 41 ch 102 SLA 1976; am §§ 13, 15, 40 ch 177 SLA 1978; am § 5 ch 103 SLA 1980; am § 5 ch 46 SLA 1982)

Revisor's notes. — In 1981, former paragraphs (1), (2), and (14), repealed in 1978, were deleted and the remaining paragraphs were renumbered accordingly.

Effect of amendments. — The 1980 amendment substituted "insured's" for "physician's" near the middle of paragraph (15) (now (12)).

The 1982 amendment rewrote paragraph (17) (now (14)).

Sec. 21.88.090. Payment of premiums; cancellation of insurance. The corporation may provide for installment payment of premiums in which case each installment is due by the date specified. The corporation may cancel any of its policies in the event of nonpayment of any premium or installment on a premium, or other charge, by mailing or delivering to the insured at the address shown on the policy and to the agency of the state issuing the insured's license written notice of cancellation. Cancellation is not effective until 30 days after the date notice is posted by the corporation. (§ 41 ch 102 SLA 1976)

Sec. 21.88.095. Transfer of corporate assets and liabilities. (a) The corporation may, subject to the prior approval of the director, transfer its assets and liabilities to a company which meets all of the following conditions:

(1) the company possesses a valid certificate of authority to transact casualty insurance business in the state; in evaluating the capital and surplus of the company for qualification for a certificate of authority, the value of the assets and liabilities transferred by the corporation may not be considered;

(2) the company pays to the corporation the full value of any surplus in the corporation not represented by any unrepaid proceeds of loans by the loan fund to the corporation;

(3) the company executes a complete reinsurance and hold harmless agreement in a form approved by the director covering all of the obligations of the corporation to its creditors and policyholders; and

(4) the company executes modifications of loan agreements with the loan fund by which the company agrees

(A) to assume the obligations;

(B) that, if at any time the company writes less than the premium levels provided in AS 21.88.055(a), the director may determine that the loan provisions shall be modified to provide a scheduled amortization repayment of the principal over a period not to exceed 10 years and at an interest rate of four points above the federal discount rate, as that rate is adjusted from time to time; and

(C) that the provision for repayment provided in AS 21.88.210(b)(1) shall be modified to provide for annual installments of at least 25 per cent of the excess of premium and investment income collected over the total of claims, reserves and expenses on the Alaska medical malpractice book of business or 25 per cent of the excess of premiums and investment income collected over the total of claims, reserves and expenses on the corporation's total book of business, whichever is greater;

(5) the company meets such other requirements as the director may reasonably require to protect the interests of the state, the health care provider insureds, the involved company, and the public;

(6) the company provides the board of governors with a written statement from the director that the company qualifies under (1) — (5)

(b) If and while the company to which the assets and liabilities of the corporation are transferred in the manner provided in (a) of this section continues to write premiums in excess of the levels provided in AS 21.88.055, it shall enjoy the benefit of the following provisions:

(1) the company is entitled to carry forward and offset against its premium tax obligation to the state the amount by which the aggregate claims paid on reinsurance assumed under (a)(3) of this section exceeds aggregate reserves on the same business established at the date of the reinsurance agreement; and

(2) the obligation to repay to the loan fund loans assumed by the company at the time of transfer of the assets and liabilities of the corporation need not be shown as a liability on the books of the corporation. (§ 16 ch 177 SLA 1978)

Secs. 21.88.110 — 21.88.180. Joint Underwriting Association. [Repealed, § 40 ch 177 SLA 1978.]

Article 3. Loan Fund.

Section
210. Fund established

Sec. 21.88.210. Fund established. (a) There is in the Department of Commerce and Economic Development a medical malpractice liability revolving loan fund to be administered by the director of insurance.

(b) Loans may be made from the fund to the corporation upon certification by the director that a loan is necessary and under the following circumstances:

(1) to provide surplus in respect to policyholders which may not exceed a total of $3,000,000 outstanding at any time; these obligations shall be subordinated to all other obligations of the corporation; loans made under this paragraph shall be repaid to the fund in annual installments of at least 25 per cent of the excess of premiums earned over the total of claims, reserves, expenses, and assessments made by the association, if any; interest shall be paid on the outstanding balance at a rate equal to seven per cent a year;

(2) if the director determines that the corporation is unable to procure reinsurance from a private casualty insurer or reinsurer for any liability incurred by contracts issued by it, additional loans up to an aggregate of $6,000,000 when taken together with loans made under (1) of this subsection to compensate for fluctuations in loss experience; loans made under this paragraph shall be in parity with all other obligations of the corporation except that they shall be subordinated to obligations of policyholders and claimants for indemnity of loss; these loans shall be repaid within five years at an annual interest rate of six per cent.

(c) If a loan is made to the corporation from the fund, the corporation shall issue a note to the fund as evidence of the loan.

(d) The director may sell at par value to the Department of Revenue the notes, security instruments and pledge agreements held by the Department of Commerce and Economic Development as security for loans made under this section. The Department of Revenue shall purchase all the notes offered until the current principal amount of the notes purchased and held by the Department of Revenue equals $6,000,000. (§ 41 ch 102 SLA 1976; am §§ 17, 18 ch 177 SLA 1978; am § 6 ch 103 SLA 1980)

Effect of amendments. — The 1980 amendment substituted "earned" for "collected" near the middle of paragraph (1) of subsection (b).

Article 4. General Provisions.

Section
900. Definitions

Sec. 21.88.900. Definitions. In this chapter

(1) "chiropractor" means a person licensed under AS 08.20;

(2) "continuous coverage" means one or more successive policy periods which is uninterrupted by cancellation or failure to renew for any reason;

(3) "corporation" means the Medical Indemnity Corporation of Alaska;

(4) "covered claim" means

(A) a claim by an injured patient reported to the corporation during the period of continuous coverage by the corporation of the insured health care provider for an act or omission in the delivery of health care services; and

(B) additional claims as defined in the policy, with the prior approval of the director, and which are reported within specified periods after the expiration of the policy;

(5) "dental hygienist" means a person licensed under AS 08.32;

(6) "dentist" means a person licensed under AS 08.36;

(7) "dispensing optician" means a person licensed under AS 08.71;

(8) "governor" means a member of the board of governors of the Medical Indemnity Corporation of Alaska;

(9) "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; a hospital as defined in AS 18.20.130, including a governmentally owned

Chapter 8' Health Care Providers Insurance.

Article
4. General Provisio : 2' 88.900

rticle 4. General Provisions.

Section
900. Definitions

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(4) "covered cl im" means

(A) a claim by n injured patient reported to the corporation during the period of co nuous coverage by the corporation of the insured health care prov er for an act or omission in the delivery of health care services; a

(B) additional laims as defined in the policy, with the prior approval of the dir tor, and which are reported within specified periods after the expira n of the policy;

(5) "dental h enist" means a person licensed under AS 08.32;

(6) "dentist" ns a person licensed under AS 08.36;

(7) "dispensin ptician" means a person licensed under AS 08.71;

(8) "governor" neans a member of the board of governors of the Medical Indemn y Corporation of Alaska;

(9) "health ca provider" means an audiologist licensed under AS 08.11; a chiropr or licensed under AS 08.20; a dental hygienist licensed under A 08.32; a dentist licensed under AS 08.36; a nurse licensed under 08.68; a dispensing optician licensed under AS 08.71; an optome ist licensed under AS 08.72; a pharmacist licensed under AS 08.80; physical therapist licensed under AS 08.84; a physician licensed un r AS 08.64; a podiatrist; a psychologist and a psychological associ e licensed under AS 08.86; a hospital as defined in AS 18.20.130, in uding a governmentally owned or operated hospital; a corporate entit covered under AS 21.88.050(b)(11); an employee of a health care prov der acting within the course and scope of employment;

(10) "hospital" eans an institution licensed under AS 18.20;

(11) "nurse" ns a person licensed under AS 08.68;

(12) "optomet " means a person licensed under AS 08.72;

(13) "pharmac " means a person licensed under AS 08.80;

(15) "physician" means a person licensed under AS 08.64;

(16) "psychologist" and "psychological associate" mean a person licensed under AS 08.86. (§ 41 ch 102 SLA 1976; am §§ 19, 20, 40 ch 177 SLA 1978; am § 6 ch 46 SLA 1982; am § 10 ch 131 SLA 1986)

Effect of amendments. — The 1986 amendment inserted "an audiologist licensed under AS 08.11" preceding "a chiropractor" in paragraph (9).

Chapter 90. General Provisions.

Section
30 — 110. [Repealed]
900. Definitions for title

Secs. 21.90.030 — 21.90.110. Definitions. [Repealed, § 23 ch 21 SLA 1985. For current law see AS 21.90.900.]

Sec. 21.90.900. Definitions for title. In this title, unless the context requires otherwise,

(1) "alien insurer" means an insurer formed under the laws of a country other than the United States of America, its states, districts, territories, and commonwealths;

(2) "authorized insurer" means an insurer authorized by subsisting certificate of authority issued by the director to transact insurance in this state;

(3) "commissioner" means the commissioner of the Department of Commerce and Economic Development;

(4) "court" means superior court;

(5) "director" means the director of the division of nsurance;

(6) "division" means the division of insurance, Department of Commerce and Economic Development;

(7) "domestic insurer" means an insurer formed under the laws of this state;

(8) "foreign insurer" means an insurer formed under the laws of a jurisdiction other than this state and includes an alien insurer;

(9) "industrial life insurance" means that form of life insurance written under policies with a face amount of $1,000 or less, with the words "industrial policy" imprint d on the face as part of the descriptive matter, and under which premiums are payable monthly or more often;

(10) "insurance" means a contract whereby one undertakes to indemnify another or pay or provide a specified or determinable amount or benefit upon determinable contingencies;

(11) "insurer" includes a person engaged as indemnitor, surety, or contractor in the business of entering into contracts of insurance or of annuity;

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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, [illegible]
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, Suite 525
Anchorage, Alaska 99503
(907) 563-3414

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

Staff
Donnette Olsen Norman
Office Manager

Joe McKay
Amy Murphy
Harriett 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

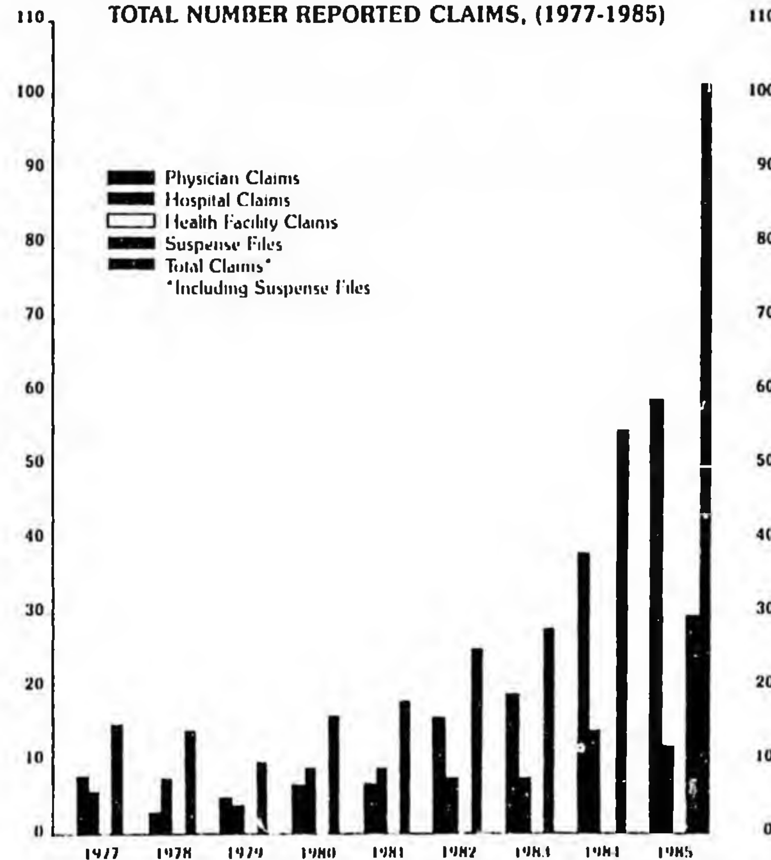
The graph to the right illustrates the continuing escalation of claims reported by MICA policyholders since the company's incorporation in 1976.

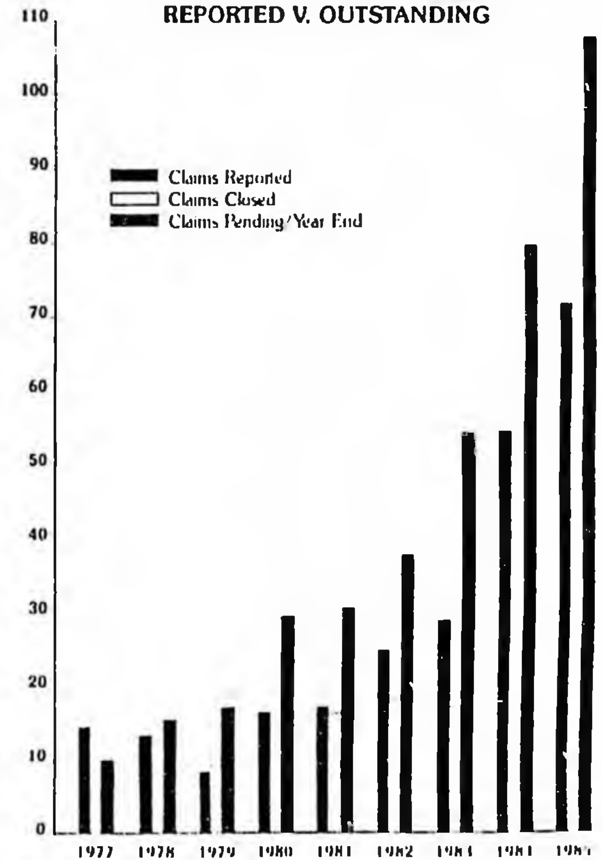
We have added a new column for 1985 entitled, "Suspense Files" as distinguished from reported claims. This new category relates to incidents reported to MICA which have some elements realistically associated with a legitimate claim, but no claim has actually been made to date. Although these potential 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.





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

being handled by MICA, either would not have occurred or, if brought, would have been rendered defensible by the proper attention to risk management principles.

Therefore, it seems that the proper response is not to continue only with the past methods or to abandon the effort altogether, but rather to look to a new means of ensuring that these basic principles are followed by physicians, nurses and hospital administrative staff to the point where they are effective.

As important as tort reform is to the Alaskan medical community, the number of claims relating to the failure to follow basic risk management principles suggest that the same physicians, nurses and hospital administrative staff could do as much, or more, to bring about a significant resolution of the malpractice problem by their own efforts.

Two alternative (and complementary) plans are presently being evaluated, one of which is beginning to be implemented at this time.

The first, a Risk identification and Resolution Program has begun, using staff and contract personnel to view clinical records and policies of insured hospitals, to make certain that those policies reflect, insofar as practical, the standards of the JCAH, ACS, ACOG, and other recognized specialty organizations.

The second program, due to be presented for consideration by the MICA Board of Governors later this year, is that of a Participatory Risk Management program which has several aspects:

(A) The publication of a series of selected risk management criteria as a part of each new or renewal policy which must be agreed to and signed by each applicant. Failure to observe these criteria which may be general, pertaining to incident reporting, medical record-keeping, etc., or specific as with standards for specific obstetrical procedures, may result in cancellation of coverage, the imposition of a substantial premium surcharge or a significant limitation on the amount of coverage as determined by MICA's Underwriting Committee.

The risk management criteria should not be viewed as oppressive or arbitrary. Actually, it represents a simple delineation of the nationally accepted and current medical professional standards for patient care and physician protection vis-a-vis medical/legal conflicts.

(B) The possible issuance of premium discounts for those policyholders who have demonstrated both an understanding and an effective use of risk management procedures in their practices, who also have a history of cooperation with, and loyalty to MICA's goals of reducing claims frequency and/or severity.

MICA's **proposed** Participatory Risk Management program is not original with the Risk Management Committee but represents a program similar to one recently instituted by Colorado's Physician-sponsored Insurance company (COPIC) as authorized by Dr Brittain, together with elements of Participatory Risk Management programs presently in use in other states.

It is our absolute belief that the Risk Management program underpins MICA's entire insurance program and that the current malpractice or medical liability crisis of 1985-86 can be, in large part, ameliorated by the proper use of those risk management procedures.

MICA's growing library of video tapes by Dr. Brittain are available to MICA insureds upon request.

	Title	Length
____	General Issues in Risk Management/ Perinatalogy	(1 hour)
____	General Issues in Risk Management/ Internal Medicine	(1 hour)
____	General Issues in Risk Management/ General Surgery	(1 hour)
____	General Issues in Risk Management/ Emergency Room	(1 hour)
____	Informed Consent and the Consent Form	(40 minutes)
____	The Value of Early Reporting of Potential Claims	(20 minutes)
____	The Quality of Medical Care	(20 minutes)
____	The Quality of the Medical Record	(20 minutes)
____	Jousting	(15 minutes)
____	Billing Practices as a Risk Management Issue	(20 minutes)
____	Managing Risk in Cancer Diagnosis	(15 minutes)
____	Managing Risk in the Emergency Room	(15 minutes)
____	Managing Risk in Obstetrics Issue	(15 minutes)

____ Videotape of the MICA Medical Malpractice Prevention Seminar held in Anchorage in May, 1985. This set of tapes includes the entire four-hour seminar including presentations by two attorneys specializing in malpractice (one defense, one plaintiff) and Dr Brittain. The ¾-inch set contains four tapes of an hour or less. The VHS set contains two tapes of two hours each.

NOTE: Several new tapes are being produced or purchased and their availability will be published in MICA's future risk management bulletins.

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 arbitrarily 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 actuarily 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

	Cost	% of Assets	Yield On Cost
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	2,670,618	27.2	11.52
Total Assets	$9,827,409	100.0%	10.90%

MATURITY

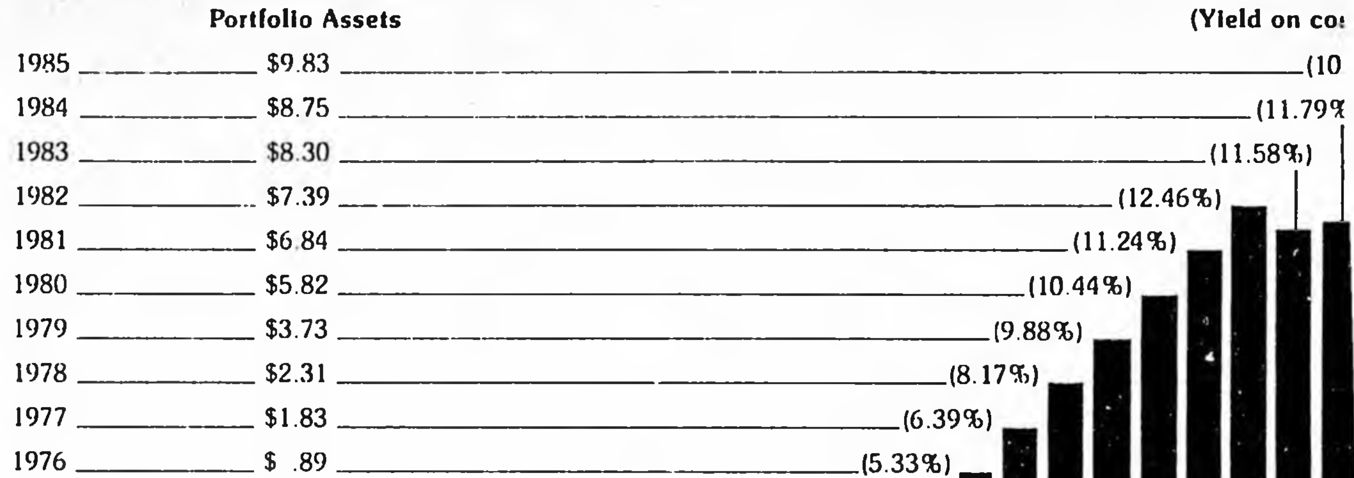
	Cost	% of Assets	Yield On Cost
Immediate Liquidity	$1,123,816	11.4%	7.63%
1986	735,510	7.5	10.93
1987	1,049,203	10.7	9.09
1988	740,344	7.5	11.37
1989	694,472	7.1	10.63
1990	698,828	7.1	12.07
1991	725,203	7.4	13.49
1992	755,375	7.7	11.43
1993	980,398	10.0	11.82
1994	927,344	9.4	12.76
1995	960,969	9.8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

*Segregated assets held to fund long term liability

INVESTMENTS

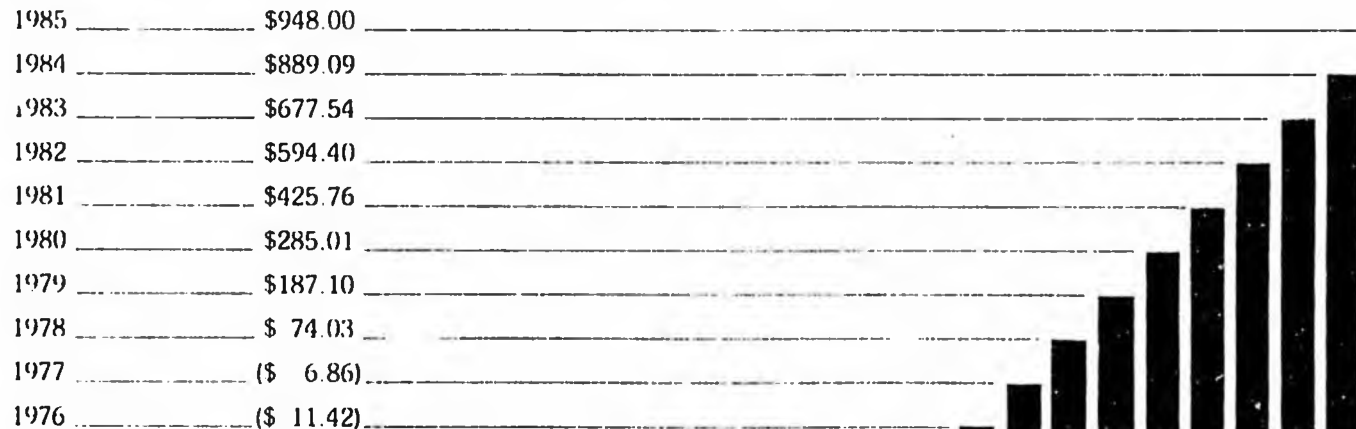
Investment Yield (Portfolio Assets)

$ 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



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	December 31 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
	10,083,458	8,975,374
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
	$10,477,562	$9,616,683
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
	7,582,691	4,581,146
NOTE PAYABLE TO STATE OF ALASKA	3,000,00	3,000,000
POLICYHOLDERS' SURPLUS (DEFICIT)	(105,129)	2,035,537
	$10,477,562	$9,616,683

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 los 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 Indemnity 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	975,753	409,273
Maturity of investments	2,000,000	1,065,000
TOTAL FUNDS PROVIDED	2,975,753	1,474,273
FUNDS USED		
Purchase of investments	3,018,735	1,508,972
DECREASE IN CASH	(42,982)	(34,699)
Cash and money market investments at beginning of year	265,126	299,825
CASH AND MONEY MARKET INVESTMENTS AT END OF YEAR	$ 222,144	$ 265,126

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	December 31 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 $400,000 were pledged to the Alaska Insurance Department to meet statutory requirements.

The Board of Governors has designated U.S. 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 initial capitalization through a loan of $3,000,000 from 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 can be 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 at 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 date MICA receives the additional funds. Interest on the 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 public 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 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 immuno deficiency 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 exceeding 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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Alaska State Legislature
Senate

Official Business

P.O. BOX V
State Capitol
Juneau, Alaska 99811

John Schedule

Best
Jay

DATE: January 18, 1988

TO: Senator Tim Kelly, Chairman
Senate Labor & Commerce Committee

FROM: Senator Jay Kerttula

RE: SB 235

At your earliest convenience, please schedule SB 235, an act relating to Grant for Hospital Insurance, for hearing before the Senate Labor & Commerce Committee.

Please contact me if you have any questions.