HB

350

HOUSE COMMITTEE REPORT

(7)

Date Referred: May 6, 1989 FURTHER REFERRALS: JUDICIARY
FINANCE

Date of Committee Action: 5/7/90

The LABOR & COMMERCE Committee considered: HB 350

HOUSE BILL NO. 350 [FUNDS FOR PHYSICIAN INSURANCE PREMIUMS]
"An Act creating the Alaska medical malpractice matching fund; and providing for an effective date."

RECOMMENDATIONS:
[ ] be replaced with CS HB 350 (L+C) [ ] the same title [✓] a new title
[ ] have attached amendment(s)
[✓] do pass
[ ] do not pass
[ ] no recommendation
[ ] individual recommendations
[ ] additional referral to the judiciary Committee

ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept)
[ ] fiscal impact _____
[✓] zero fiscal note _____
[ ] zero with analysis _____

APPROVES PREVIOUS: (Date/Dept)
[ ] fiscal note(s) _____
[ ] zero fiscal note(s) _____
[ ] zero fn/analysis _____

SIGNING DO PASS:

Finkelstein

Dave Donley Donley

Mackie Kubley

Mark Boyer Boyer

SIGNING: (Check approp. column)

	Do Not Pass	No Rec	Amend
[illegible]			
Drew Lerman Lerman	Collins		X
Virginia M Collins	X		
creates more problems than it solves!			
R.C. Bunch Boucher			
[illegible]			

Dave Donley
Chairman's Signature

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CS HB 350 (L&C)
PUBLISH DATE:

FISCAL NOTE

REQUEST:

Revision Date:
Title: Alaska Medical Malpractice Matching Fund
Sponsor: Donley
Requestor: H. Labor & Commerce

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

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

ANALYSIS: (Attach a separate page if necessary) No fiscal impact for FY 90.

Prepared by: Don Koch, Chief of Market Surveillance
Division: Insurance
Phone: 465-2515
Date: 2/5/90

Approved by Commissioner: Larry Mercuilieff
Date: 6 Feb 90
Agency: Department of Commerce & Economic Development

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

LW/dg16253D/2590a

STATE OF ALASKA

OFFICE OF THE GOVERNOR

BILL ANALYSIS

DEPARTMENT	DIVISION	BILL NUMBER	SPONSOR
Commerce & Econ. Dev.	Insurance	HB 350	Donley and Gruenberg

SHORT TITLE OF BILL: An Act creating the Alaska Medical Malpractice Matching Fund; and providing for an effective date

DEPARTMENT POSITION: Neutral

PREPARED BY	DATE	COMMISSIONER'S SIGNATURE	DATE
	11/21/89		12 Dec 89

SUMMARY

OTHER AGENCIES AFFECTED BY BILL	CONSTITUENT GROUP(S) AFFECTED BY BILL
	Health Care Providers
ORGANIZATIONAL SUPPORT FOR BILL	ORGANIZATIONAL OPPOSITION TO BILL

FISCAL IMPACT: ☒ NONE ☐ FISCAL NOTE ATTACHED

BACKGROUND/LEGISLATIVE INTENT

ANALYSIS OF BILL/PROGRAM EFFECTS

See Attached

AMENDMENTS PROPOSED

5744D/112089a

PLEASE ATTACH A SEPARATE SHEET FOR ADDITIONAL COMMENTS OR ANALYSIS.

01-000 (Rev. 12/88)

ANALYSIS OF BILL/PROGRAM EFFECTS - HB 350

SECTION 1. FINDINGS AND PURPOSE.

The Legislature finds that the cost of medical malpractice insurance for some health care providers has reduced the availability of health care in Alaska and has created a situation in which there may not be adequate compensation in cases of medical malpractice because claims may be uninsured.

SECTION 2.

House Bill 350 adds a new section, AS 21.88.310, Medical Malpractice Matching Fund, to Title 21 setting up a partial subsidy of medical malpractice premiums based upon a ratio comparing the health care providers annual net income and insurance premium.

The subsidy would only be available to a health care provider insured by Medical Indemnity Corporation of Alaska (MICA). The potential for legal and constitutional challenges from other insurers providing or seeking to provide medical malpractice insurance should be considered.

The subsidy may create a situation in which it is advantageous for a health care provider to secure insurance from MICA with a government subsidy rather than secure insurance through the normal market place from an insurer whose premium, but for the subsidy, may be lower than MICA's.

Although the legislative finding is that it is in the best interest of the state that health care providers be insured in order to provide adequate compensation in cases medical malpractice (and that health care providers not be exposed to the substantial financial risks of an uninsured claim), health care providers are not required to be financially responsible in cases of medical malpractice by securing a minimum mandatory coverage for such claims.

The section provides no distinctions among the type of health care providers. A health care provider may be an individual, a partnership, or a corporation. All would appear to be eligible for the subsidy, even though their real financial condition may be substantially different. For example, a physician may be an employee as well as an owner of a health care provider which is incorporated. Either the individual physician or the corporate health care provider may secure and pay for the insurance covering the physician's practice. If the corporation appears unprofitable, even though the individual physician receives substantial income through a high salary, it may be eligible for a state subsidy. Furthermore, a physician may have substantial income from business activities related to the provision of health care but not necessarily received as income from providing health care services. A physician may have an interest in a pharmacy, laboratory, or other related business which generates substantial net income but is not directly from the physician providing health care services.

If the health care provider leases office space from a separate legal entity it has an interest in, a similar issue arises. What monies should be considered received as income from providing health care services and what monies should be considered costs for providing those services need to be clarified. It is appropriate to provide the Medical Indemnity Corporation of Alaska statutory guidance regarding these significant issues.

Section (d) of this section provides that the subsidy be equivalent of the entire medical malpractice premium attributable to obstetrics and gynecology for a physician who practices in a rural area. It appears that other health care providers involved in obstetrics and gynecology would not be recipients of a full subsidy. What constitutes a rural area is undefined. It is unclear if a physician with some patients in a truly rural area would receive the 100% subsidy upon meeting the qualification even though the majority of the practice is conducted in an urban area. Perhaps a provision defining "rural" and requirements of rural residency as well as a truly rural clientele may be appropriate.

The economic impact upon the Department of Commerce and Economic Development would be nominal because the Medical Indemnity Corporation of Alaska administers the fund. However, the liability of MICA itself is neither eliminated nor funded. For example, any litigation or legal challenges to the existence and/or operation of the fund would be funded from the corporation's general administrative budget. It may be appropriate for the Legislature to fund such costs if any are incurred. Otherwise, such expenses may represent significant contingent liabilities on MICA's balance sheet.

5744D
112089a

Amendment to

CS HB 350

P. 3 Lines 15- 17
Remove Subsection (2)

p3 Line 18
~~(b)~~ renumber subsection (2)
as subsection (3)

p3 Line 21 After: subsection (2)
add a new subsection:

(3) A percent equal to the result of subtracting the number of births from 120, if the physician practices in a rural community and acts as the attending physician in at least 50 but less than 70 births.

p.4 Line 2 after subsection (3) add a new subsection:

(4) 50 percent, if the physician practices in a rural community and acts as the attending physician in 70 or more births.

Formula 120 - (# of births)

Number of Births in Rural Area	Percent Size of Payment to Physician
20	100%
30	90%
40	80%
50	70%
60	60%
50 or more	50%

6-1380H
Ford
4/24/90

Original sponsor(s): REP. DONLEY, Gruenberg, Boyer

IN THE HOUSE BY THE JUDICIARY COMMITTEE

CS FOR HOUSE BILL NO. 350 (Judiciary)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act creating the Alaska medical malpractice grant fund; and providing for an effective date."

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

* Section 1. FINDINGS AND PURPOSE. (a) The legislature finds that

(1) it is in the best interest of the state that physicians be insured in order to provide adequate compensation in cases of medical malpractice and to ensure that physicians providers are not required to bear unreasonable financial risks imposed by an uninsured claim;

(2) due to the cost of medical malpractice insurance some physicians have chosen to become uninsured, which exposes the physician and patients to unreasonable risk, forces some physicians to cease their medical practice, and also acts as a general disincentive to practicing medicine in the state;

(3) the number of physicians in the state on a per capita basis is among the lowest in the nation, particularly in the rural communities, and that the shortage of physicians is increasing; and

(4) in rural communities of the state the high cost of medical malpractice insurance poses a serious threat to public health and safety.

(b) It is the purpose of this Act to provide immediate and substantial relief to physicians by making adequate malpractice insurance available, while the legislature continues to develop legislation intended to reduce the cost of medical malpractice insurance.

* Sec. 2. AS 21.88 is amended by adding a new section to article 3 to read:

Sec. 21.88.310. MEDICAL MALPRACTICE GRANT FUND. (a) The Alaska medical malpractice grant fund is established in the corporation. The fund consists of legislative appropriations.

(b) The corporation shall administer the fund. Money in the fund may be used to make grants to pay a portion of the cost of medical malpractice insurance incurred by physicians who are eligible under (c) of this section and to pay the cost of administering the fund.

(c) To receive a grant from the fund a physician must purchase at least the minimum malpractice insurance policy offered by the corporation and meet conditions established by the corporation for the purpose of increasing the number of licensed physicians who practice medicine in the state. A grant awarded by the corporation must be applied to medical malpractice insurance premiums (1) in a medical specialty for which a physician is unable to obtain medical malpractice liability insurance at premium rates that are reasonable when compared to the physician's income and premium rates for other medical specialties; or (2) incurred by a physician primarily practicing as a medical specialist in a geographic area that is substantially under served when compared to other areas of the state served by physicians practicing in the same specialty. The corporation shall annually publish a list of medical specialties and geographic areas eligible for a grant under this section.

(d) The corporation may not pay an insurance surcharge imposed on a physician's medical malpractice insurance.

(e) The corporation shall establish procedures for applying for grant funds provided under this section.

(f) The state shall indemnify the corporation for any legal costs, attorney fees, or judgments that result from the administration

or operation of the fund.

(g) In this section, "physician" means a person licensed to practice medicine under AS 08.64.

* Sec. 3. AS 21.88.310 is repealed July 1, 1993.

* Sec. 4. This Act takes effect immediately under AS 01.10.070(c).

6-1380E
Ford
3/1/90

Original sponsor(s): REP. DONLEY, Gruenberg, Boyer

IN THE HOUSE BY THE LABOR & COMMERCE COMMITTEE

CS FOR HOUSE BILL NO. 350 (L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to the medical malpractice revolving loan fund; creating the Alaska medical malpractice matching fund; and providing for an effective date."

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

* Section 1. SHORT TITLE. This Act may be known as the Alaska Childbirth Care Incentive Act.

* Sec. 2. FINDINGS AND PURPOSE. (a) The legislature finds that

(1) it is in the best interest of the state that physicians be insured in order to provide adequate compensation in cases of medical malpractice and to ensure that physicians providers are not required to bear unreasonable financial risks imposed by an uninsured claim;

(2) due to the cost of medical malpractice insurance some physicians have chosen to become uninsured, which exposes the physician and patients to unreasonable risk, forces some physicians to cease their medical practice, and also acts as a general disincentive to practicing medicine in the state;

(3) the number of physicians in the state on a per capita basis is among the lowest in the nation, particularly in the rural communities, and that the shortage of physicians is increasing; and

(4) in rural communities of the state the high cost of medical malpractice insurance poses a serious threat to public health and safety.

(b) It is the purpose of this Act to provide immediate and substantial relief to physicians by making adequate malpractice insurance available, while the legislature continues to develop legislation intended to

reduce the cost of medical malpractice insurance.

* Sec. 3. AS 21.88.210(b) is amended to read:

(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 <u>that</u> [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 percent of the excess of premiums earned over the total of claims, reserves, expenses, and assessments made by the association, if any; interest <u>may not be charged</u> [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; <u>interest may not be charged on the outstanding balance</u> [AT AN ANNUAL INTEREST RATE OF SIX PER CENT].

* Sec. 4. AS 21.88 is amended by adding a new section to article 3 to read:

Sec. 21.88.310. MEDICAL MALPRACTICE MATCHING FUND. (a) The Alaska medical malpractice matching fund is established within the

Department of Commerce and Economic Development. The fund consists of legislative appropriations.

(b) The corporation shall administer the fund. Money in the fund may be expended to pay the cost of medical malpractice insurance incurred by physicians who are eligible under (c) of this section and to pay the cost of administering the fund.

(c) A physician who purchases at least the minimum malpractice insurance policy offered by the corporation is eligible to receive a payment from the fund. The amount a physician is eligible to receive is equal to a percentage of that portion of the physician's annual malpractice insurance premium that provides coverage for obstetrics and gynecology as follows:

(1) 25 percent, if the physician practices in an urban community;

(2) 50 percent, if the physician practices in a rural community and acts as the attending physician in 20 or more births a year;

(3) 100 percent, if the physician practices in a rural community and acts as the attending physician in at least one but fewer than 20 births a year, or provides prenatal care to at least one but fewer than 20 patients a year.

(d) If a physician eligible to receive a payment under (c) of this section practices in both a rural and an urban community, the amount the physician receives shall be prorated under guidelines established by the corporation. The corporation may not pay an insurance surcharge imposed on a physician's medical malpractice insurance.

(e) The corporation shall establish procedures for applying for matching funds provided under this section.

(f) The state shall indemnify the corporation for any legal

costs, attorney fees, or judgments that result from the administration or operation of the fund.

(g) In this section,

(1) "physician" means a person licensed to practice medicine under AS 08.64;

(2) "rural community" means a community with less than 5,000 permanent residents and less than 10,000 permanent residents within a radius of 20 miles from the U.S. Post Office nearest to the center of the community;

(3) "urban community" means a community with 5,000 or more permanent residents or 10,000 or more permanent residents within a radius of 20 miles from the U.S. Post Office nearest to the center of the community.

* Sec. 5. AS 21.88.310 is repealed July 1, 1993.

* Sec. 6. This Act takes effect immediately under AS 01.10.070(c).

HOUSE COMMITTEE REPORT

(7)
Date Referred: March 8, 1990 FURTHER REFERRALS:

FINANCE

Date of Committee Action: _____

The JUDICIARY Committee considered: HB 350

HOUSE BILL NO. 350 FUNDS FOR PHYSICIAN INSURANCE PREMIUMS

"An Act creating the Alaska medical malpractice matching fund; and providing for an effective date."

RECOMMENDATIONS:

[ ] be replaced with _____ [ ] the same title
[ ] a new title

[ ] have attached amendment(s)

[ ] do pass

[ ] do not pass

[ ] no recommendation

[ ] individual recommendations

[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept)

[ ] fiscal impact_____
[ ] zero fiscal note_____
[ ] zero with analysis_____

APPROVES PREVIOUS: (Date/Dept)

[ ] fiscal note(s) _____
[ ] zero fiscal note(s)_____
[ ] zero fn/analysis _____

SIGNING DO PASS:

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SIGNING: (Check approp. column)

	Do Not Pass	No Rec	Amend
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_____
Chairman's Signature

B

HOUSE COMMITTEE REPORT

3/8

(7)
Date Referred: May 6, 1989 FURTHER REFERRALS: JUDICIARY FINANCE

Date of Committee Action: 3/7/90

The LABOR & COMMERCE Committee considered: HB 350

HOUSE BILL NO. 350 [FUNDS FOR PHYSICIAN INSURANCE PREMIUMS]
"An Act creating the Alaska medical malpractice matching fund; and providing for an effective date."

RECOMMENDATIONS:
[✓] be replaced with CS HB 350 (L+C) [ ] the same title [✓] a new title
[ ] have attached amendment(s)
[✓] do pass
[ ] do not pass
[ ] no recommendation
[ ] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept) APPROVES PREVIOUS: (Date/Dept)

[ ] fiscal impact _____ [ ] fiscal note(s) _____
[✓] zero fiscal note dept. committee sub. dlw [ ] zero fiscal note(s) _____
[ ] zero with analysis _____ [ ] zero fn/analysis _____

SIGNING DO PASS:

Finkelstein
Dave Donley Donley
Mary Greenberg
Mark Boyer Boyer

SIGNING: (Check approp. column)

	Do Not Pass	No Rec	Amend
[illegible]			
Drew Lerman Lerman	Collins		X
Virginia M Collins	X		
creates more problems than it solves!			
R.C. Boucher Boucher		X	
[illegible]			

Dave Donley
Chairman's Signature

LAW OFFICES

Luce & Hensley

A PROFESSIONAL CORPORATION

1016 WEST SEVENTH AVENUE

ANCHORAGE, ALASKA 99501

L. AMES LUCE
DAN A. HENSLEY

TELEPHONE (907) 276-1191
FAX:(907) 277-4864

February 5, 1990

Via Fax

Rep. Dave Donley, Chairman
Labor and Commerce Committee
Alaska State Legislature
P.O. Box V (MS 3100)
Juneau, Alaska 99511

Re: House Bill Nos. 334, 336, 337, 349 and 350

Dear Representative Donley:

I have reviewed several bills pending in the Labor and Commerce Commi ee which address issues concerning medical malpractice insurance and medical malpractice litigation. As an attorney who represents plaintiffs in medical negligence cases, I am very pleased to see that your committee is taking steps to address the real problems involved in the medical insurance "crisis" -- that is, availability of insurance and access to the justice system. What a refreshing approach when compared to some prior legislative attempts to solve these problems by reducing or eliminating the rights of injured victims of negligence.

I do have some minor suggestions concerning some portions of the bills which are addressed below. However, please understand that I wholeheartedly support the intent of this legislative package.

House Bill 334, which requires professionals to obtain malpractice insurance, is a step in the right direction in my view. However, I am concerned that the bill, as presently drafted, does not require liability insurance unless the professional has had a judgment entered against him or her. This exception raises two questions.

First, a professional who holds himself out to the public as competent in an area should back that representation with insurance, regardless of whether he or she has been the subject of a negligence judgment. Second, although this exception was apparently designed to focus on the professional with a "track record" of negligence, it does not appear to apply to the professional who may have settled a series of negligence claims short of trial to avoid a negligence judgment. Despite these concerns, I strongly urge the passage of some legislation requiring mandatory liability insurance for professionals.

House Bill 336 makes changes in the medical malpractice advisory panel law presently on the books. The important modifications are the increase in the size of the panel, the addition of non-health care providers to the panel, and a change in the prohibition on discovery in litigation presently written in the law.

There is an additional, significant problem with the panel statute which is not addressed by this bill. That problem is the use to which a panel report may be made in court. Several physicians who testified at the recent committee hearings believe that the role of the panel is only to address "biological" issues, without regard to the important legal-medical issues raised in the litigation. Moreover, many physicians with whom I have spoken personally believe that their role as panel members is to "educate the judge" rather than to prepare a report for use by the trial jury in deciding the case.

Nevertheless, under present law, a panel report may be introduced into evidence at trial <u>without</u> the members of the panel actually testifying. In addition, the Alaska Supreme Court has held that an expert advisory panel report may be used as the basis for summary judgment against a party. <u>Kendall v. State</u>, 692 P.2d 953, 955 (Alaska 1984). Finally, under present administrative rules, although the court appoints the expert advisory panel, often over the objection of a party, a party who wishes to have a member of the panel testify at trial (either to support the panel report or to expose fallacies in the report) must pay for that physician's deposition and appearance at trial.

If the purpose of the panel proceeding is to provide "screening" of cases, it is superfluous. Competent plaintiff's lawyers screen difficult medical negligence cases prior to filing them. The high costs of pursuing a medical negligence case act as a deterrent to filing a non-meritorious case. There are existing court rules for addressing frivolous claims (Rule 82 awards to the prevailing party; Rule 11 sanctions).

If the panel is to remain a part of Alaska's medical negligence law, its role should be clearly defined. I suggest that House Bill 336 be amended to add the following:

> A.S. 09.55.536(e) is repealed and re-enacted to provide: The panel's report is advisory only. It may not be introduced into evidence at trial and its members may not be called as witnesses. In awarding costs and attorneys' fees at the conclusion of litigation, the trial court may consider the panel report.

Finally, House Bill 350, concerning creating the Alaska Medical Malpractice Matching Fund, is an extremely important piece of legislation. The passage of this bill will do much to alleviate the problems faced by rural physicians in obtaining insurance, without forcing rural Alaskans to settle for second rate medical care.

Thank you for the opportunity to comment on these legislative proposals. If I can answer any questions or provide additional information, I will be happy to do so.

Sincerely yours,

LAW OFFICES OF LUCE & HENSLEY, P.C.

Dan A. Hensley

DAH:fs
off.dah.let.rep.dav.don.1

ALL CLAIMS - INCEPTION THROUGH 1988

By Payment Size

INDEMNITY PAYMENT	#OF SUITS/CLAIMS	PERCENTAGE
0	165	61
1-1,000	6	2
1,001-5,000	14	5
5,001-10,000	12	4
10,001-25,000	14	5
25,001-50,000	17	6
50,001-75,000	7	3
75,001-100,000	10	4
100,001-150,000	6	2
150,001-200,000	8	3
200,001-500,000	4	1
500,001-750,000	4	1
750,001-2,000,000	2	1
2,000,001-3,000,000	2	1
	271	

Average Claim - $48,731

Average Claim where indemnity payment was made - $124,353

	Physician Claims	Physician's Named	Number of Physicians Insured
1976	2		58
1977	4		88
1978	5		88
1979	2		97
1980	10		121
1981	7		144
1982	15		200
1983	15		230
1984	29	39	285
1985	43	63	325
1986	35	67	315
1987	27	29	303
1988	20	21	279

MICA Medical Indemnity
Corporation of Alaska

ALEUT PLAZA
4000 OLD SEWARD HWY., SUITE 203
ANCHORAGE, ALASKA 99503

COVER SHEET FOR FACIMILE TRANSMITTAL

(OUR FAX NUMBER IS - 562-7804)

TO: Bill Brock

Juneau, Alaska

FAX # 00

ATTENTION: Mary Pierce

FROM: Art Stanford

RE: Prenatal Coverage Only

PAGES:

IF YOU SHOULD NOT RECEIVE THE NUMBER OF PAGES INDICATED ON THIS COVER SHEET, PLEASE CONTACT OUR OFFICE AT 563-3414.

Attached is the form letter we sent last summer to all of our policyholders regarding this new specialty class.

Only Crossroads Medical Center (Glennallen) responded and they also submitted the written protocols with the delivering physician in Anchorage.

Stan Jones, M.D. of Haines had supported and pushed for this re-classification but declined the coverage when it was finally made availablebecause "it was still to expensive for his low volume of O.B. patients".

MICA Medical Indemnity
Corporation of Alaska

ALETT PLAZA
4000 OLD SEWARD HWY., SUITE 203
ANCHORAGE, ALASKA 99503

Bulletin

RE: New Specialty Class: Prenatal Coverage Only

Dear Policyholder:

Your Board of Governors is pleased to announce the creation of a new specialty class for those physicians who wish to continue providing prenatal care to their patients with delivery being performed elsewhere by a collaborating OB/GYN or Family Practictioner in an urban area hospital.

This new specialty classification has been assigned a class 2 rating which represents a premium reduction of approximately 48% over the rate for complete Family Practitioner obstetrical coverage.

The only requirements for this specific coverage are that the collaborating physician must have malpractice insurance (not necessarily with MICA) and approval by MICA of the written protocols between yourself and the physician doing the actual delivery. The protocols must be signed by both physicians, be specific as to the number of patient visits to the delivering physician prior to the due date as well as the frequency and type of the prenatal procedures that will be performed.

Your company is pleased to provide this new coverage which has been tailored to meet specific and current needs of many of our rural physician policyholders. The coverage will allow our physicians to continue providing virtually full term obstetrical services to their patients while at the same time providing optimal facilities for the actual delivery.

Please contact the MICA Underwriting Department if you have any questions regarding this new prenatal only coverage.

Very truly yours,

Art Stanford
Underwriting Manager

AS:sm

7/29/88

MICA Medical Indemnity Corporation of Alaska

ALEUT PLAZA
4000 OLD SEWARD HWY., SUITE 203
ANCHORAGE, ALASKA 99503
(907) 563-3414

December 29, 1989

Representative Max Gruenberg
House Labor and Commerce Committee
House of Representatives
P.O. Box V
Juneau, AK 99811

Dear Representative Gruenberg:

The House Labor and Commerce Committee had hearings on November 30, 1989 at which time I was asked to have an "informal" chat with the committee. Since I wasn't prepared to testify, I gave you some estimated premium figures and promised to follow up with exact rate information.

MICA's 1990 Premium Schedule is enclosed for your information. The committee had asked me questions at the hearings specifically relating to the cost of insurance to physicians delivering babies. I mentioned that the majority of our phsician policyholders have limits $500,000 per claim, $1,000,000 aggregate. Physicians delivering babies are Class 3 on the schedule. Assuming a physician had policy limits of $500,000/1,000,000 and had been insured with MICA for five or more years his premium for 1990 would be $30,162. (This is about $20,000 less than I quoted to you.)

Another question is the difference in premium between a Family Practioner doing obstetrics and those who were not. Assuming the same scenerio as above and that the Family Practioner not doing obstetrics was doing minor surgery the difference would be $14,046. In other words, the Family Practioner who delivers babies pay $14,046 to do so (or about 1/2 of the total premium is for obstetrical coverage).

I hope that this letter and the attached premium schedule better answers your questions. If you have any further questions, please feel free to call me.

Sincerely,

Mary A. Pierce
Executive Director

MAP/blb

Enclosure

MICA

Medical Indemnity
Corporation of Alaska

ALEUT PLAZA OFFICE BUILDING
4000 OLD SEWARD HIGHWAY, SUITE 203
ANCHORAGE, ALASKA 99503
TELEPHONE (907) 563-3414

1990

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

PROFESSIONAL LIABILITY COVERAGES

Explanation of Policy:

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

MICA's premium rates are derived from the historical pattern of reported claims resulting from the performance of professional services which form a "stair step" with an increasing number of claims being reported each year until the fifth year. In the first year, only about 19 % of the total claims resulting from professional services are reported; the second 39 %; the third 78 %; the fourth 93 %; the fifth and subsequent years, about 100 %.

Cost:

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

All policies issued by MICA are renewed on January 1 of each year. Your first years and renewal rates are pro-rated from the first date of coverage (inception date) of the original policy. For example, if your continuous coverage became effective on July 1, 1986, your annual renewal premium on January 1, 1990 would be pro-rated from January 1 through June 30 on the fourth year rates and from July 1 through December 31 on the fifth year rates.

Limits of Liability:

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

$200,000 per occurrence/$600,000 aggregate per calendar year.
$500,000 per occurrence/$1,000,000 aggregate per calendar year.
$1,000,000 per occurrence/$2,000,000 aggregate per calendar year.
$1,000,000 per occurrence/$3,000,000 aggregate per calendar year.

Reporting Endorsement (Tail Coverage) *

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

"Tail" coverage must also be recognized when a physician reduces rating classification to offset reduced premium charges while subsequently reported claims from the higher specialty continues to occur. This is currently being accomplishedby charging "tail" premium on a pro-rata basis as between the two speciality classes when the policy is ultimately terminated.

Cost:

The cost of "tail" coverage will depend upon the length of time you have been insured with MICA, limits of liability purchased, physician's rating class and will be subject to the company's rules, rates, and rating plans in effect at the time the Unlimited Reporting Endorsement is requested.

*** The policy limits purchased for the Unlimited Reporting endorsement will be applicable just as if the policy had not been cancelled or terminated and all subsequently reported claims had been reported during the last policy year.**

Part Time Practitioners:

Class 0, 1, 1-A, 2, 2-A and Family practitioners in any class: 35 % of the scheduled annual premiums for 10 hours or less per week practice: 65 % of the scheduled annual premium for 20 hours or less per week practice.

Comprehensive General Liability Coverages:

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

This coverage is limited to premises actually occupied by our insured in rendering professional services. For example, if an insured occupied one suite of a building, coverage would be limited to only that suite. An entire building cannot be covered under the Comprehensive General Liability Endorsement unless the insured or the insured's employees occupy the entire building in the rendering of medical services.

Corporate/Partnership/Group Professional Liability:

This optional coverage is available at no additional charge to solo practitioners and group practices, providing each member or employed physician carries coverage through the Company. The only requirement for group limits is that the limits of liability on the group may never be higher than the lowest limit carried by any member of the group. The separate limits of liability for the corporation/partnership/group does not apply to policyholders who are solo practitioners nor does it apply concurrently or on an excess basis to the physician (s) scheduled on the policy or associated with the same medical organization who also allegedly provide neligent patient care for the same occurrence.

This form provides individual limits of liability to each physician named on the policy schedule except these limits shall not be concurrent nor excess to the corporate limits of liability stated in the previous paragraph.

Optional Shared Limits Professional Liability Group Coverage:

This optional coverage is available through the Company for your group at reduced premium levels. (see discount schedule that follows). One master policy is issued with each associated or employed physician covered by endorsement.

Coverages are limited to the course and scope of employment or association with your group. **The combined clinic/group insureds are subject to the single limits of liability per occurrence and annual aggregate limits as procured.**

Completion of the Physician's and Surgeon's Professional Liability Group Application is required, along with completion of individual application for each physician to be insured.

Discounts Per Limits of Liability

# Doctors on Policy	$500,000	$1,000,000
1	0	0
2	9%	7%
3	11%	9%
4	12%	10%
5	13%	11%
6	14%	12%
7	15%	13%
8	16%	14%
9+	17%	15%

Installments - Deferred Payments:

Initial policy issuance subject to deposit of $1,000 or two month's annual premium. Deferred payments are available in quarterly or semi-annual installments payable: 35%, 25 %, 25 % and 15 % quarterly or 60 % and 40 % semi-annually. Premium invoices should be paid upon receipt and the policy is subject to immediate cancellation if payment is not received by the first day of the quarter in which the premium is earned. Carrying charges are computed at 10 % annual simple interest on the unpaid balance.

The full premium for an Unlimited Reporting Endorsement must be received by the company within twelve months following its inception date. The Unlimited Reporting Endorsement will be cancelled at the end of this twelve month period if the full premium has not been received at that time, and only premium earned for this twelve month Reporting Endorsement period will be charged in accordance with rates actuarially determined and filed with the Division of Insurance.

CLAIMS - MADE PREMIUM SCHEDULE

Effective January 1, 1990

LIMITS OF LIABILITY: EACH CLAIM AND ANNUAL AGGREGATE

	1st - 5th Years	$200,000/$600,000	$500,000/$1,000,000	$1,000,000/$2,000,000 $1,000,000/$3,000,000 *
CLASS 0				
1st year rates	Jan. 1, 1990	2,924	3,182	3,601
• 2nd year renewal rates	Jan. 1, 1989	3,467	4,026	4,857
• 3rd year renewal rates	Jan. 1, 1988	4,559	5,607	7,119
• 4th year renewal rates	Jan. 1, 1987	5,026	6,271	8,058
• 5th year renewal rates	Jan. 1, 1986	5,177	6,485	8,361
CLASS 1				
1st year rates	Jan. 1, 1990	3,798	4,305	5,067
• 2nd year renewal rates	Jan. 1, 1989	4,828	5,809	7,220
• 3rd year renewal rates	Jan. 1, 1988	6,724	8,497	11,031
• 4th year renewal rates	Jan. 1, 1987	7,517	9,612	12,599
• 5th year renewal rates	Jan. 1, 1986	7,772	9,970	13,103
CLASS 1-A				
1st year rates	Jan. 1, 1990	4,548	5,270	6,326
• 2nd year renewal rates	Jan. 1, 1989	5,997	7,341	9,268
• 3rd year renewal rates	Jan. 1, 1988	8,584	10,980	14,391
• 4th year renewal rates	Jan. 1, 1987	9,657	12,482	16,499
• 5th year renewal rates	Jan. 1, 1986	10,001	12,964	17,176
CLASS 2				
1st year rates	Jan. 1, 1990	5,338	6,286	7,651
• 2nd year renewal rates	Jan. 1, 1989	7,228	8,953	11,414
• 3rd year renewal rates	Jan. 1, 1988	10,542	13,593	17,928
• 4th year renewal rates	Jan. 1, 1987	11,909	15,503	20,605
• 5th year renewal rates	Jan. 1, 1986	12,348	16,116	21,464
CLASS 2-A				
1st year rates	Jan. 1, 1990	7,098	8,550	10,605
• 2nd year renewal rates	Jan. 1, 1989	9,971	12,547	16,196
• 3rd year renewal rates	Jan. 1, 1988	14,905	19,417	25,811
• 4th year renewal rates	Jan. 1, 1987	16,928	22,235	29,755
• 5th year renewal rates	Jan. 1, 1986	17,577	23,139	31,020

* PREMIUM COST IS 4% ABOVE $1,000,000/$2,000,000 LIMITS.

Claims-made premium prepared by Milliman & Robertson, Inc., consulting Actuaries for the Medical Indemnity Corporation of Alaska, are based on a five year pricing step for reported claims adjusted annually for claims experience.

•Retroactive dates and renewal premium apply to 2nd through 5th year annual renewal. First year physicians are subject to first year rates.

•All policies are renewed each year on January 1. All 1st and renewal premiums are prorated subject to the first day of coverage under the original policy.

INTRODUCTION

A statute of limitations is a law that requires a party who believes himself or herself to have been injured to bring an action against the responsible party within a certain time frame. Most states and the District of Columbia have enacted such statutes to protect architects, engineers and others in the construction industry from exposure to unlimited liability on individual projects.

These laws attempt to strike a reasonable balance between the interests of those who may be potentially "harmed" and the rights of defendants to be free of potential suits after a reasonable period of time. In states where no such legislation is in effect, design professionals face a lifetime of liability on each of their projects.

Most state laws relating to design professionals are actually "statutes of repose." These are laws that set time periods within which a suit may be filed regarding a cause of action regardless of when the cause occurred. The usual statute of limitations starts to run from the data of injury or other cause of action and actions brought after the end of the statutory time period are barred. The statute of repose establishes the beginning of the time period not the cause of action, such as an injury, but another event, such as the substantial completion of a building. When the specified time period has expired, suits for actions occurring after that period are barred.

State statutes of limitations for design professionals and the construction industry come under attack in the courts periodically, and may in fact be found to be unconstitutional. A review of the case law referred to in those situations will provide a complete understanding of the problems involved in an individual state. It is important that AIA state and local components, as well as individual architects, closely monitor activity relative to their state's statutes and that industry members now seeking new or amended laws carefully review related legislative and judicial activity to track a well-defined path through the legislative process.

AIA's "Compendium: State Statutes of Limitations" is timely and should be a useful working tool for those dealing with this issue.

TABLE OF CONTENTS

SUMMARY

Alabama:	No statute of limitations at this time; previous law declared unconstitutional
Alaska:	Six years from substantial completion
Arizona:	Does not have a statute of limitations for design professionals
Arkansas:	Five years from substantial completion
California:	Ten years from substantial completion
Colorado:	Ten years from substantial completion
Connecticut:	Seven years from substantial completion
Delaware:	Six years from substantial completion
District of Columbia:	Ten years from substantial completion
Florida:	Four years from actual possession by owner
Georgia:	Ten years from substantial completion
Hawaii:	Ten years from substantial completion
Idaho:	Six years from substantial completion
Illinois:	Ten years from substanital completion plus four years from discovery of cause to take action
Indiana:	Ten years from substantial completion
Iowa:	Does not have a statute of limitations for design professionals
Kansas:	Ten years after performance of services
Kentucky:	Five years after performance of services
Louisiana:	Ten years after occupation by owner
Maine:	Ten years after substantial completion
Maryland:	Ten years after improvement becomes available
Massachusetts:	Six years after performance of design or construction
Michigan:	Six years after occupancy or acceptance of improvement
Minnesota:	Fifteen years after substantial completion
Mississippi:	Six years after written acceptance or use
Missouri:	Ten years after completion of construction

Montana:	Ten years after completion of construction, plus one year for action after cause
Nebraska:	Ten years after professional service is rendered
Nevada:	Eight years after substantial completion
New Hampshire:	No statute of limitations at this time; previous law declared unconst tutional
New Jersey:	Ten years after performance of services and construction
New Mexico:	Ten years after substantial completion
New York:	Three years after cause for action
North Carolina:	Six years after substantial completion
North Dakota:	Ten yea - after substantial completion
Ohio:	Ten yea: ; after performance of services and construction
Oklahoma:	Five years after substantial completion, plus two years for action after cause
Oregon:	Six years after substantial completion
Pennsylvania:	Twelve years after substantial completion
Rhode Island:	Ten years after substantial completion
South Carolina:	No statute of limitations at this time; previous law declared unconstitutional
South Dakota:	No statute of limitations at this time; previous law declared unconstitutional
Tennessee:	Four years after substantial completion
Texas:	Ten years after substantial completion
Utah:	Seven years after substantial completion
Vermont:	Six years after cause of action
Virginia:	Five years after performance of services
Washington:	Six years after substantial completion
Wisconsin:	Six years after substantial completion
Wyoming:	Ten years after substantial completion

THE WALL STREET JOURNAL.

FRIDAY, APRIL 28, 1989

MARKETPLACE

Media: *Newspaper publishers vow continued cost-cutting* *Page B3.*

Who's News: *American Express revamps top posts at travel group* *Page B4.*

Medical-Malpractice Insurance Rates Fall

Drop in Number Of Claims Cuts Insurers' Costs

By James R. Schiffman
Staff Reporter of The Wall Street Journal

There is finally something to cheer about on the health-cost front. For the first time in a decade, medical-malpractice insurance rates are falling.

St. Paul Cos., the nation's largest medical-malpractice insurer, just two weeks ago said it plans to cut rates for doctors this year by an average of 14% nationwide, the first decrease since 1978. Farmers Group Inc., which covers hospitals and health-maintenance organizations, already has slashed premiums up to 15%. And premiums of physician-owned insurance companies will either stay as they are or decrease a little, says Douglass Phillips, president of the Physicians Insurance Association of America.

Although increases in malpractice premiums slowed in 1987 and 1988, this is the first year since the late 1970s that average rates actually are declining. "I'm very relieved, and I'm very happy," says Jonathan S. Ehrlich, an Atlanta obstetrician who stands to save $13,000 annually in reduced premiums. "Two or three years ago you couldn't see any end to the spiral."

Fewer Claims

So: What's driving rates down? Patients are filing fewer malpractice claims than in the mid-1980s, and the costs to settle them aren't escalating as fast as they were in previous years. As a result, a number of insurers say they anticipate having to pay out less money this year than last to settle claims and thus can afford to drop rates.

Nobody knows exactly why fewer claims are being filed. But experts point to a variety of contributing factors. Malpractice cases are getting more expensive, more complex and harder to win in court. At the same time, juries are getting stingier with awards to wronged patients, and many states have either put caps on payouts or passed laws to block frivolous suits. Doctors also are getting better at taking preventive measures to head off malpractice cases.

To be sure, many doctors and insurance-company officials aren't convinced that rates will keep dropping, and in a few states premiums still are going up. Doctors point out that malpractice rates went down for a few years in the late 1970s, only to rise almost geometrically in the 1980s. Another worry: At least some of the decrease in jury awards stems from health-care cost cutting and lower inflation in the early '80s, when cases now being settled were filed. So today's skyrocketing health costs could bring larger verdicts in the future.

"It's great news if it lasts, but no one is ready to bet that it will last," Kirk Johnson, American Medical Association's general counsel, says of the decreases in premiums. James E. Davis, the AMA's president, cautions that it will take another two of declines before doctors believe the trend. "It's premature for anyone to suspect that physicians' fees are going to drop immediately," he says.

Malpractice Awards

Compensatory damages awarded by U.S. juries in single-plaintiff medical-malpractice cases:

	AVERAGE AWARD	MEDIAN AWARD	LARGEST (in millions)	NUMBER OF MILLION-DOLLAR AWARDS
1983	$887,938	$2[illegible]476	$25.0	69
1984	640,619	200[illegible]40	27.6	71
1985	1,179,096	40[illegible]00	12.7	79
1986	1,478,028	8[illegible]970	15.8	92
1987	924,416	61[illegible]000	13.0	62
1988	732,445	400[illegible]00	8.1	54

NOTE: Figures for 1988 are preliminary

Source: Jury Verdict Research Inc.

But some insurers say the down draft seems stronger than it ever was a decade ago, raising hope that a cycle of lower rates may have begun. One indication: St. Paul's reductions cut across most medical specialties, including oft-sued obstetricians and neurosurgeons.

The benefits of lower malpractice rates could be far-reaching. The AMA says that malpractice premiums have been the fastest-rising expense item for physicians in the 1980s, and already some doctors are considering cutting fees. Dr. Ehrlich, the Atlanta obstetrician, says the malpractice-premium cuts might enable him to reduce his rates to patients.

Malpractice lawyers say the growing complexity and cost of suing are making patients less litigious and lawyers more picky. Fees for expert witnesses have increased up to twentyfold in recent years, and more and more experts are needed to pick apart the vastly more complicated technologies used these days in medicine. Five years ago, William Bird, president of the Georgia Trial Lawyers Association and a medical-malpractice specialist, says he took cases of patients whose doctors failed to diagnose appendicitis. No more. The cost of bringing such cases to court won't justify the return, he says, adding: "Today, it requires almost a catastrophic injury."

While most patients settle malpractice claims out of court, the few who go to trial are finding juries less receptive. The average and median amounts of money awarded by juries in the U.S. for medical-malpractice cases (excluding punitive damages) have been falling markedly since reaching a peak in 1986. The number of million-dollar verdicts also has dropped precipitously since then.

Some legal and insurance experts say public outrage about the huge malpractice settlements of the early 1980s may have damped the sympathies of juries. Others think conservative judges appointed during the Reagan years may have influenced verdicts to push back awards. But everybody agrees that new laws passed in at least 19 states since 1986 have had some chilling effect.

Some states have capped payouts for pain and suffering. Others have adopted measures aimed at cutting frivolous lawsuits. In Georgia, the Legislature passed a law requiring that an attorney bringing a malpractice suit include an affidavit of support from a medical expert. Such affidavits are costly; and lawyers, who generally get paid in malpractice cases only if they win, now must invest more money in each malpractice case. "I think [the affidavit law] discourages attorneys from working on cases," Mr. Bird says.

Unnecessary Tests

Doctors and hospitals have also contributed to lowering malpractice-insurance rates by adopting costly strategies to thwart potential malpractice cases. Doctors readily admit to ordering unnecessary tests to protect themselves from malpractice cases. Ira M. Hardy, a Greenville, N.C., neurosurgeon, says he's sure about half of the magnetic resonance imaging scans he orders—at $1,000 a shot—will come up negative. "I have to do it" to avoid opening up the possibility of suit, he says.

"Risk management" initiatives involve adopting strict clinical standards. Anesthesiologists at Harvard University's teaching hospitals, for example, tightened rules in 1985 to require, among other things, monitoring every five minutes the blood pressures and heart rates of patients on the operating table. Since then, malpractice payouts have dropped and so have insurance rates through the university's malpractice program.

Doctors also are finding that a mea culpa can avoid a lawsuit. It isn't uncommon for a surgeon to, say, cut into the wrong foot of a patient, says Mr. Phillips of the Physicians Insurance Association. Doctors are learning that explaining what happened and apologizing can deter patients from suing. Concludes Mr. Phillips: "Communicating with the patient is probably the most important aspect of loss prevention."

FAX TRANSMITTAL

DATE: 3-29-90

TO: Representative Peter Goll

COMPANY:

LOCATION:

FAX #: 4635661

FROM: MARY PIERCE
MICA
4000 Old Seward Highway, Suite 203
Anchorage, Alaska 99503
Telephone: (907) 563-3414
FAX#: (907) 562-7804

Page 1 of 3

RE: Deliver to:
Representative Goll

RSVP

This is written testimony to back-up my verbal testimony this afternoon on HB 350.

IF YOU DO NOT RECEIVE A COMPLETE AND LEGIBLE COPY OF THIS FAX PLEASE CALL THE MICA OFFICE NUMBER ABOVE

MICA Medical Indemnity Corporation of Alaska

ALEUT PLAZA
4000 OLD SEWARD HWY., SUITE 303
ANCHORAGE, ALASKA 99503
(907) 563-3414

March 28, 1990

Representative Peter Goll, Co-Chair
House Judiciary Committee
House of Representatives
P..O. Box V
Juneau, AK 99811

Dear Representative Goll:

MICA has been requested to attempt to give the Judiciary Committee some idea of the potential costs of CSHB350 as it is currently written. I believe the purpose is dual; to help you better evaluate the bill, and to finalize a fiscal note.

MICA has completed this task, but we need to preface this report as it is based on the following understandings.

1.) We have based this on our current policyholders who are paying premiums for delivering babies. We have no idea how many other physicians in the state might become MICA insureds under this program, or how many of our own insureds may decide to deliver babies.

2.) These figures show ultimate costs. In other words, they are based on all of our policyholders. We have no way of knowing whom, if anyone, will avail themselves of this program.

3.) We have reviewed every application to arrive at what their individual classification would be if they were not delivering babies. We needed to subtract that to make the formula work. In some cases, our assumptions may be incorrect.

4.) We have concluded that "urban" means the following areas:

Anchorage
Mat-Su (Palmer, Wasilla, etc.)
Fairbanks
Juneau
Kenai/Soldotna

5.) We have assumed in the case of OB/GYN's that a part of their premium would be for gynecology and have only discounted the part of their premium for obstetrical coverage. If that is not a correct assumption and all of their premium should be included, then the total amount subsidized would be $54,837.00.

Medical Indemnity Corporation of Alaska

Legislative Section	Total Premiums	Subsidized Premium
(C)(1) OB/GYN's	$219,346	$22,332
G.P.'s/F.P.'s	$324,157	$40,155
(C)(2) 1-20 Births	$115,108	$58,551
(C)(3) 21-70 Births	$173,546	$63,494
(C)(4) 71 + Births	———	0
TOTALS	$832,157	$184,532

I have no idea what this may cost us to administrate because it would depend on how many people we have in the program. Certainly no more than 10% of the subsidized premium amount, assuming you want us to have separate record keeping on this group.

We are submitting this to you and the committee as a written accompaniment to our verbal testimony which I will make at the hearings on Thursday, March 29, 1990.

Sincerely,

Mary A. Pierce

Mary A. Pierce
Executive Director

MAP/blb

HOUSE LABOR AND COMMERCE COMMITTEE

ALASKA STATE LEGISLATURE P.O. BOX Y, JUNEAU 99811

(907) 465-3892

November 23, 1989

M E M O R A N D U M

To: Members, House Labor and Commerce Committee

From: Representative Dave Donley, Chair
House Labor and Commerce Committee

Re: HB 350 - Alaska Medical Malpractice Matching Fund

HB 350 establishes the Alaska medical malpractice matching fund under the Department of Commerce and Economic Development, to be administered by the Medical Indemnity Corporation of Alaska (MICA). The fund may be used to pay part of the cost of medical malpractice insurance for eligible physicians.

The purpose of HB 350 is outlined in Section 1 of the bill. The sliding scale established under the Act to determine eligibility for reimbursement from the matching fund is geared toward physicians who provide "high risk" care to local communities, such as OB-GYN and emergency room services and are therefore the ones who usually pay the highest premiums.

An initial appropriation of $500,000 is made to the matching fund through HB 349, the companion funding bill. The funding source is the medical malpractice liability revolving loan fund under AS 21.88.210. Only physicians insured by MICA are eligible for the matching fund.

A copy of a recently enacted Arizona law establishing a similar program is included in your committee file along with related information from the Legislative Research Agency. Representatives from MICA and other interested providers will testify on HB 349 and HB 350 during our November public hearings.

dd/gbi89
b/hb350

HOUSE LABOR AND COMMERCE COMMITTEE

ALASKA STATE LEGISLATURE P.O. BOX Y, JUNEAU 99811

(907) 465-3892

April 30, 1989

M E M O R A N D U M

To: Mike Ford, Attorney
Legislative Legal Services

From: Ginger Baim, aide to
Representative Dave Donley, Chair
House Labor and Commerce Committee

Re: Bill drafting request - Medical Malpractice Matching Fund

As per our conversation last week, I am writing to ask that you prepare a bill draft(s) for introduction by the House Labor and Commerce Committee as outlined below:

1. Prepare a bill draft establishing a uniform premium tax of three percent for all lines of insurance in the state. Please speak with Paul Roller, Director of the Division of Insurance, for further information regarding current premium tax practices. Include "program receipt" language in the bill requiring the Division to separately account for the increased revenues resulting from the uniform tax so that they may be appropriated by the Legislature into the MICA Medical Malpractice Matching Fund.

2. Prepare a bill/s draft making MICA's loans into grants and requiring that MICA make an initial payment of $500,000 into the Medical Malpractice Matching Fund established under the following section. Please speak with Mary Pierce of MICA to get information regarding MICA's loan obligations and internal operating procedures.

3. Prepare a bill draft creating the Alaska Medical Malpractice Matching Fund under MICA:

   a. Draft a "findings and purpose" section:*

   - it is in the state's best interest that medical providers be insured so that victims of medical malpractice may be adequately compensated and so that providers are not at risk of financial disaster when faced with an uninsured settlement.

   - the cost of medical malpractice insurance has forced many providers to go "bare" which exposes both them and their patients to unacceptable risk; has caused providers to cease delivering necessary medical services; acts as a disincentive for medical providers to practice in Alaska.

   - Alaska has one of the lowest providers per capita ratios in the nation and it is in the state's best interest to increase the number of physicians in the state, particularly in rural areas.

- there is a particular crisis in rural areas of the state because of the high cost of medical malpractice insurance that threatens the public health and safety

- the purpose in enacting this act is to provide immediate and substantial relief to medical providers so that they can afford to purchase medical malpractice insurance while the Legislature continues to work on measures designed to reduce costs of medical malpractice insurance

b. The fund shall consist of money appropriated by the Legislature and payments by MICA into the fund.

c. MICA shall make an initial deposit into the fund of $500,000.

d. MICA shall distribute the money in the fund on a sliding scale established in "e".

e. Establish a sliding scale to reimburse medical providers for part of the amount that their annual medical malpractice premium exceeds ten percent of their gross personal annual income based on the following formula:

ANNUAL GROSS INCOME	PREMIUM	% OF INCOME	% TO BE MATCHED	AMOUNT TO MATCHED	MATCH
$100,000.	$11,000.	11	1%	$ 1,000	51%
$100,000.	$12,000.	12	2%	2,000	52%
$100,000.	$13,000	13	3%	3,000	53%
$100,000.	$14,000	14	4%	4,000	54%
$100,000.	$15,000	15	5%	5,000	55%
$100,000.	$20,000	20	10%	10,000	60%
$100,000.	$30,000	30	20%	20,000	70%
$100,000.	$40,000	40	30%	30,000	80%
$100,000.	$50,000	50	40%	40,000	90%
$100,000.	$60,000	60	50%	50,000	100%

Interpretation: If a provider earns $100,000 and pays an annual premium of $50,000 (or 50%) then the medical malpractice matching fund will pay 90 percent of $40,000.

* This should be a gradual scale, a percent at a time, so there are no "jumps"

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f. EXCEPTIONS: Exceptions to the sliding scale should include a provision that:

- there will be no match for any portion of a premium that is a "surcharge".

- the fund will pay 100% of that portion of a premium that is for OBGYN coverage for providers operating in rural areas that deliver fewer than 10 babies a year or provide prenatal care for fewer

than 20 patients a year.

- the matching fund is only available to providers insured by MICA

g. Providers must submit a copy of their federal income tax filing to MICA so that their annual gross personal income may be established. MICA shall develop forms and procedures for applying for matching funds.

h. Insert a "sunset" clause ending the medical malpractice matching fund five years from its enactment with any remaining funds lapsing into the general fund.

The Committee would like a draft document to work from as soon as possible with the intent to introduce the bill prior to adjournment and to take it up in interim hearings so it can be finalized and ready to move at the beginning of next session.

Please call me at 4954 if you have any questions or need additional information.

* Feel free to clean up the language in this section and to add or delete anything you think is appropriate.

Signed into law by
Arizona Governor Mofford
June 28, 1989

Senate Engrossed House Bill

ISSUED BY
JIM SHUMWAY
SECRETARY OF STATE

State of Arizona
House of Representatives
Thirty-ninth Legislature
First Regular Session
1989

Chapter 290
HOUSE BILL 2467

AN ACT

MAKING AN APPROPRIATION TO THE DEPARTMENT OF HEALTH SERVICES FOR THE PURPOSE OF PAYING ADDITIONAL MEDICAL MALPRACTICE PREMIUM COSTS FOR PERFORMING THE DELIVERY OF INFANTS AT CERTAIN RURAL HOSPITALS; PRESCRIBING IDENTIFICATION OF QUALIFYING HOSPITALS AND PHYSICIANS; PRESCRIBING EVALUATION OF REQUESTS FOR ASSISTANCE; PRESCRIBING LIMITATIONS; AND PRESCRIBING STUDIES AND REPORTS.

Be it enacted by the Legislature of the State of Arizona:

Section 1. Appropriation; purpose; exemption

A. The sum of one hundred ninety-five thousand dollars is appropriated from the state general fund to the department of health services for the purposes described in subsection B of this section.

B. The department shall identify areas in the state that are underserved with regard to obstetrical services. For purposes of this section, an area shall be considered underserved with regard to obstetrical services if the area satisfies any of the following:

1. Fifty per cent or more of resident live-births occur outside the city or town of residence.

2. Cities or towns where obstetric services are threatened with discontinuance.

3. Cities or towns having a population of less than ten thousand where prenatal services are not provided by a physician.

4. Cities or towns having a population of less than ten thousand where obstetric backup services for a physician are not available.

5. Cities or towns where the average number of prenatal visits are less than the state average.

C. The department shall identify those physicians who practice in areas defined in subsection B of this section who meet the following:

1. Shall have current obstetrical delivery privileges at one or more rural, non-federal hospitals.

2. Shall be a registered provider with the Arizona health care cost containment system who has established a contract for obstetrical services with at least one or more of the system's prepaid contractors.

3. The physician shall be licensed by the appropriate licensure board.

D. Family physicians who perform less than fifty deliveries per year and who are required to pay an additional premium to perform obstetrical services shall be eligible to receive an amount not to exceed five thousand dollars. Family physicians who perform more than fifty deliveries per year and who are required to pay an additional premium to perform obstetrical services shall be eligible to receive an amount not to exceed ten thousand dollars. Obstetricians who are required to pay an additional premium to provide obstetrical services shall be eligible to receive an amount not to exceed ten thousand dollars. Payment of one-half of the financial assistance identified in this section shall be contingent upon receipt of the report required pursuant to subsection F of this section. The second payment shall be paid upon receipt of the second report required pursuant to subsection F of this section.

E. Physicians seeking financial assistance shall respond to the department's notice within thirty days of receipt of such notice in a format prescribed by the department. The department shall evaluate the physician's request for financial assistance and shall classify the requests according to the city or town's need for obstetrical services and ability to meet all or at least one of the criteria specified in subsection B of this section. The highest classification shall be assigned to those cities or towns which meet all of the criteria specified in subsection B of this section. The lowest classification shall be assigned to those cities or towns which meet at least one of the criteria specified in subsection B of this section. The department shall establish contracts with those physicians whose requests are assigned the highest classification. If funds remain available, the department shall proceed in descending order to establish contracts with those physicians whose requests have been assigned a lower classification until funding is depleted.

F. The financial assistance awarded pursuant to subsection E of this section shall be used for each physician who meets the qualifications of subsection C of this section, is under contract with the department to remain in practice in the rural area for the contract year and who provides a report upon completion of one-half of the contract term and upon conclusion of the contract to the department which identifies the number of women to whom the physician has provided medical services during delivery, the ages of the women, the number of prenatal visits each woman received, the number of women who are at or below federal poverty standard, the number of Arizona health care cost containment system enrolled women served and the insurance status of the women. Contracts pursuant to this section are exempt from the requirements of title 41, chapter 23, Arizona Revised Statutes.

G. The university of Arizona college of medicine shall examine the adequacy of obstetrical services in rural underserved areas. The university of Arizona college of medicine shall develop a plan which may include the use of educational subsidies designed to overcome any identified inadequacies in the delivery of obstetrical care or other primary health care services in rural Arizona. The plan shall include recommendations regarding educational subsidies, identification of funding needs, identification of alternative funding sources and necessary legislative action to implement the recommendations. The university of Arizona college of medicine shall submit their report to the governor, president of the senate and speaker of the house of representatives by February 1, 1990.

H. The department shall submit a written report to the governor, the president of the senate and the speaker of the house of representatives on or before February 1, 1990 on the number of physicians who have applied and the number of physicians who received financial assistance provided pursuant to subsection E of this section. One year from the effective date of this section, the department shall evaluate the effectiveness of the financial assistance provided pursuant to this section and shall on or before January 1, 1991, submit a written report of its findings to the governor, the president of the senate and the speaker of the house of representatives. The report shall include recommendations regarding continuation of the financial assistance, the number of physicians who received financial assistance who plan to continue providing prenatal and delivery services in rural Arizona and legislative action necessary to improve the control, distribution and cost effectiveness of the financial assistance.

I. The appropriation made in this section is exempt from section 35-190, Arizona Revised Statutes, relating to lapsing of appropriations.

Approved by the Governor June 28, 1989.

Filed in the Office of Secretary of State June 28, 1989

MICA Medical Indemnity Corporation of Alaska
ALEUT PLAZA
4000 OLD SEWARD HWY., SUITE 203
ANCHORAGE, ALASKA 99503
(907)563-3414

June 21, 1989

Dave Donley Representative
Alaska State House
3111 "C" Street Suite 450
Anchorage, Alaska 99503

Dear Dave,

Thank-you for spending the time on the phone discussing issues effecting medical malpractice. As you know I was anxious to discuss bills proposed by you because of a special meeting of our Board of Governors on June 21, 1989, to discuss this proposed legislation. I wanted to clarify intent to properly present them for discussion to the Board.

You, your aide, Ginger Bain, and I had discussed the sliding scale matching fund or premium subsidy during the legislative session. It is my understanding after our recent discussion that HB350 should reflect what we discussed. I questioned if the algebraic formula in the bill accomplished your purpose. You suggested we work on the details later. Your intent as I understood it is to find a way to subsidize rural physicians especially those delivering babies to maintain the availability of healthcare throughout the state.

Companion bills to this matching fund, HB349 and HB355, were also discussed. You suggested that MICA could be made exempt from premium taxes when reviewing MICA's tax status. We also discussed forgiving our loans or turning them into grants It was my understanding that we should work over the summer with the legislative drafter amending these bills. If you have him contact me I will happy to work with him.

We also discussed the concept of an administrative system. MICA has been investigating this concept for sometime and I would like to discuss this with you at some future date when we have more time.

I know you will have a busy summer. Thanks for taking the time again to disc. ss this with me. I hope we can get together in the fall.

Regards.

Mary A. Pierce
Executive Director

HB350

MICA Medical Indemnity Corporation of Alaska

ALEUT PLAZA
4000 OLD SEWARD HWY., SUITE 203
ANCHORAGE, ALASKA 99503
(907) 563-3414

February 23, 1990

Representative David Donley, Chairman
House Labor and Commerce Committee
State of Alaska
P.O. Box V
Juneau, Alaska 99811

Dear Chairman Donley:

I was requested in a legislative hearing on Tuesday, February 20, to supply the committee with numbers of deliveries made per physician from information gathered on a questionnaire distributed by ASMA to private practice physicians in the state.

The information follows:

Family or General Practitioners doing Obstetrics

	Fewer than 10	10-20	21-40	41-100	101-200	over 200
Anchorage *		1	3	6		
Fairbanks		4	1			
Kenai Peninsula		2	4	3	1	
South East	1	3	6	3	1	
North				1**		

* - Anchorage includes Mat-Su Valley

** - covered by Federal Government

General Surgeons (C-Section only)

	Fewer than 10	10-20	21-40	41-100	101-200	over 200
Southeast			1	1		

Obstetricians

	Fewer than 10	10-20	21-40	41-100	101-200	over 200
Anchorage			1***	2	11	3
Kenai Peninsula				1		
Fairbanks					4	

*** This physician noted that he only does 40 deliveries because CNA (his carrier) increases the rates with an increase in deliveries.

The following are the statistics I testified to during the hearings.

Total: 321 Uninsured: 48 or 15%
187 of total doctors reside in Anchorage

	Delivering or Had Been Delivering Babies	Not Doing Deliveries
Total	131	190
Uninsured	27 or 20.6%	21 or 11%
Uninsured Located	14 - Anchorage	14 - Anchorage
	7 - Kenai Peninsula	4 - Kenai Peninsula
	2 - Fairbanks	3 - Southeast
	2 - North	
	2 - Southeast	
Stopped Coverage before 1987	6	9
% of Gross Income willing to Pay		
Minimum	5%	1%
Maximum	25%	10%
Average	10%	5-10%
No Longer Delivering Babies	42 * or 32%	

* - 33 doctors in the insured group were no longer delivering babies all due to cost.

- 9 doctors in the uninsured group were no longer delivering babies partially due to cost.

I hope this information proves useful. I've attached a copy of the questionnaire form that was distributed to the 616 private practice physician.

Sincerely,

Mary A. Pierce

Mary A. Pierce
Executive Director, MICA

Alaska State Medical Association

4107 Laurel Street Anchorage, Alaska 99508 (907) 562-2662 (Fax) 561-2063

December 29, 1989

Dear Colleague:

Enclosed is a survey intended to derive some needed information from Alaska physicians. As most of you know, the state medical association is taking a leadership role in trying to help the state legislature with the complicated issues surrounding tort reform and/or liability insurance. Before we can confront the legislature, we need factual data. This survey will help us gather the data regarding Alaska and match it with the larger picture of the nation and other nations of the world.

The information will be kept confidential. It is important that you realize that your name or even the coding will only be known to two or three members of the ASMA staff. Secondly, the information you provide should be flexible. You may add more data than is questioned. We want this information to be interactive so that you feel you have a part in deriving this survey. Make it as specific as you want to: give us your thoughts.

The code in the right hand corner is in three parts. The first part: G = Group, S = Solo (single practioner). The second part is the speciality code as desiginated by the American Medical Association. A copy of the list with codes is on the back of the survey form. The third part is location and that is: N = North, W = West, A = Anchorage, F = Fairbanks, SE = Southeast, and P = Kenai Peninsula. Please check the code to be sure that it does apply to you and to your practice.

I wish I could offer a prize or an incentive for completing this survey. The best I have to offer is our thanks and to tell you that you are taking part in some of the most important issues that we, as organized medicine, face today. Thank you for helping.

Cordially,

Russell A. Huffman, M.D.
President

RAH/jlw

LIABILITY INSURANCE SURVEY

1. Do you now carry medical liability insurance? _____ Yes _____ No

   If yes, how long? _____

   With what carrier? _____

   If no, when did you cancel? _____

   Do you contemplate not carrying it in the near future, i.e. within the year? ___Yes ___No

   If you don't carry insurance: Is this a philosophical choice (i.e., you don't believe in it; if you don't have it you won't get sued, etc.) _____ Yes ____ No

   Is this economic, or because of other factors that have forced your choice? ___ Yes ___ No

2. What proportion, i.e. percent, of your net income is the medical liability premium?

3. What is your opinion as to a "fair" liability premium, as either an absolute dollar figure, or percent of gross, or percent of net?

4. Is there a level of premium that you would pay, i.e. what do you think you could afford?

5. Do you deliver babies? _____ Yes _____ No

   If yes, how many per year? _____

   What premium do you pay simply for obstetrics, in excess of your liability premium without obstetrics?

   _____

   If no, was the cost of malpractice liability a major factor? _____ Yes _____ No

6. If there was an affordable insurance as described above, would you then change to doing obstetrics?

Please verify the code in the top right hand corner of this survey (as noted in the accomanying letter) and return the survey in the enclosed envelope. Thank you.

Dave or Ginger,
letter previously
sent
Mary

December 29, 1989

Representative Dave Donley, Chairman
House Labor and Commerce Committee
House of Representatives
P.O. Box V
Juneau, AK 99811

Dear Representative Donley:

The House Labor and Commerce Committee had hearings on November 30, 1989 at which time I was asked to have an "informal" chat with the committee. Since I wasn't prepared to testify, I gave you some estimated premium figures and promised to follow up with exact rate information.

MICA's 1990 Premium Schedule is enclosed for your information. The committee had asked me questions at the hearings specifically relating to the cost of insurance to physicians delivering babies. I mentioned that the majority of our phsician policyholders have limits $500,000 per claim, $1,000,000 aggregate. Physicians delivering babies are Class 3 on the schedule. Assuming a physician had policy limits of $500,000/1,000,000 and had been insured with MICA for five or more years his premium for 1990 would be $30,162. (This is about $20,000 less than I quoted to you.)

Another question is the difference in premium between a Family Practioner doing obstetrics and those who were not. Assuming the same scenerio as above and that the Family Practioner not doing obstetrics was doing minor surgery the difference would be $14,046. In other words, the Family Practioner who delivers babies pay $14,046 to do so (or about 1/2 of the total premium is for obstetrical coverage).

I hope that this letter and the attached premium schedule better answers your questions. If you have any further questions, please feel free to call me.

Sincerely,

Mary A. Pierce
Executive Director

MAP/blb

Enclosure

MICA Medical Indemnity Corporation of Alaska

RATE CHANGES	M.D.	HOSPITAL
1981	+ 2.5 %	- 6.0 %
1982	+ 5.0 %	+ 5.0 %
1983	- 6.5 %	+ 20.0 %
1984	+ 7.5 %	+ 7.5 %
1985	+15.0 % *	+ 15.0 %
1986	+90.0 % **	+107.0 %
1987	+25.0 %	+ 42.0 %
1988	+23.0 %	0 %
1989	0 % ¥	0 % ¥

* Some specialties had class change providing larger increases:
Examples:
Family Practice doing O.B. +86% (Changed to Class 2B)
Emergency Medicine +66% (Changed to Class 2A)

**Increases for 1M/2M limits were greater (approximately 125%)

¥ Potential Increase for MICA's 1989 Tax liability is 12.6% for physicians and 10.5% for hospitals.

Dave or Ginger,
Percentage increases in rates. Also previously provided.
Mary

MICA Medical Indemnity Corporation of Alaska

ALEUT PLAZA
4000 OLD SEWARD HWY., SUITE 203
ANCHORAGE, ALASKA 99503
(907) 563-3414

February 13, 1990

Representative Dave Donley, Chairman
Labor and Commerce Committee
House of Representatives
State of Alaska
PO Box V
Juneau, Alaska 99811

Dear Chairman Donley:

I testified in front of the House Labor and Commerce Committee and was requested to submit my comments in writing. Please share this written testimony with the other committee members.

Chairman Donley and Committee members, I am Mary Pierce, Executive Director of MICA.

CSHB334 - Requiring insurance of outstanding judgement.

We wanted to make a few brief informational comments on this bill. We, like all insurance companies, have underwriting requirements to write physicians. We do gather previous claims experience and our Underwriting Manager and the Underwriting Committee may not cover an applicant based upon that experience. In other words, we do not offer insurance coverage to all applicants. If this bill is passed we wanted the committee to know that physicians with an outstanding judgement may not be able to procure coverage and therefore not able to practice.

CSHB336 - Medical Malpractice Advisory Panels.

We feel strongly that if current Medical Malpractice Advisory panels are to work they need to be comprised of experts, more importantly specialists who can understand the technical medical procedures and make assessments that offer the judge and both parties accurate medical conclusions.

We fight now to obtain the appropriate physicians specialist on a panel. It does no good whatsoever to have a family practitioner on a panel where we have technical complications involving an orthopedic procedure. We feel that adding lay people to this panel would not make it any better. In fact, the time the panel would need to review a case would increase as the physicians would have to educate the lay people.

We ask you to not further dilute the credibility of the panel but in fact maintain it as an "expert" advisory panel membered with medical experts. We suggest that lay people have a place in the system and that is on the jury. If you must put a lay person on the panel to make sure the doctors play straight then please make them non-voting members on these highly technical issues.

Medical Indemnity Corporation of Alaska

CSHB337 - Mandatory insurance requirements for hospitals.

Our comments here are similar to HB334. We do have underwriting requirements for hospitals. We are concerned since we are the only company offering coverage in the state to the rural hospitals that we may not chose to underwrite a hospital. We want the committee to understand that we are unwilling to compromise our standards because the strength and stability of those standards allow us to continue in business. We are not interested in becoming a substandard market or acquiring risks that may lead to our insolvency. It is our commitment to be here to write malpractice for the majority.

HB349 - Money from Medical Malpractice Revolving Loan Fund.

This fund was established to fund the operations of MICA. We have borrowed from it twice and have an outstanding balance of $2,402,286 on the first note and $800,000 on the second note. This fund has been important to us both in our original capitalization and also as surplus. This surplus is critical when being reviewed by reinsurers because it helps add stability to our small company. Needless to say, we are concerned about any depletion to the fund.

HB350 - Matching Fund.

We are certainly supportive of the concept of a matching fund. We do have some questions regarding this in legislation.

First of all, I believe I understand the intent of the formula but for the life of me, I can't get it to work. Perhaps someone can explain it to me.

We are also curious as to a definition of the term "rural" as it applies to the bill.

Finally, we have some concerns if we are to administer this fund.

1) The first is a potential restraint of trade problem that might occur by a physician with another carrier being denied access to the fund. It is at the very least a potential conflict of interest.

2) Secondly, if we do administer it we are concerned with the increase in administrative costs to us. Our question is therefore one of developing a budget and receiving compensation to administer the fund.

Again, we don't disagree in concept to the idea of a matching fund but do have questions regarding the mechanics.

Thank you for your time. I will be happy to answer any questions.

Sincerely,

Mary A. Pierce

Mary A. Pierce
Executive Director

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH V STATE CAPITOL
JUNEAU ALASKA 99811
907 465 3800

MEMORANDUM February 20, 1990

SUBJECT: Alaska medical malpractice matching fund - HB 350

TO: Representative Dave Donley

FROM: Michael F. Ford
Legislative Counsel

You have asked if creating the Alaska medical malpractice matching fund raises any constitutional problems. Under Article VII, section 4, of the Alaska Constitution, the legislature has a broad mandate to protect the public health. I do not see that providing subsidized malpractice insurance in order to ensure that medical services are available, violates the state constitution.

Please contact me if you have further questions.

MFF:pl
WKP2/065

MICA Medical Indemnity Corporation of Alaska

ALEUT PLAZA
4000 OLD SEWARD HWY., SUITE 203
ANCHORAGE, ALASKA 99503
(907) 563-3414

April 2, 1990

Representative Peter Goll, Co-Chairman
House Judiciary Committee
House of Representatives
P..O. Box V
Juneau, AK 99811

Dear Representative Goll:

There were several questions from members of the Judiciary Committee regarding my testimony on March 29th. I felt that it might be helpful if, as a member of this committee, you received information answering all the questions.

First of all, I appreciate your interest in both MICA and your concern for the healthcare delivery system in the state. I have included information that might prove useful in understanding specific questions on how MICA does business and also, general information on physician demographics, specifically on those delivering babies.

Informational Items

1.) A letter to the House Labor and Commerce Committee. This provides information on where physicians practice, how many deliveries they do, and if they are insured. Included is a copy of the questionnaire that was distributed to the 614 private practice physicians in the state that we used to develop these statistics.

2.) Another letter to Representative Donley, a 1990 MICA premium schedule is enclosed.

3.) A schedule of rate changes since 1981.

4.) Response to questions about obstetrical claims to Department of Health and Social Services. This should answer all questions regarding loss experience.

Please let me know if I can provide you with other information that would prove useful.

Sincerely,

Mary A. Pierce

Mary A. Pierce
Executive Director

MICA Medical Indemnity Corporation of Alaska

ALEUT PLAZA
4000 OLD SEWARD HWY., SUITE 203
ANCHORAGE, ALASKA 99503
(907) 563-3414

February 23, 1990

Representative David Donley, Chairman
House Labor and Commerce Committee
State of Alaska
P.O. Box V
Juneau, Alaska 99811

Dear Chairman Donley:

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Sincerely,

Mary A. Pierce

Mary A. Pierce
Executive Director, MICA

Alaska State Medical Association

4107 Laurel Street Anchorage, Alaska 99508 (907) 562-2662 (Fax) 561-2063

December 29, 1989

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Cordially,

Russell A. Huffman, Jr. M.D.
President

RAH/jlw

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1. Do you now carry medical liability insurance? _____ Yes _____ No

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December 29, 1989

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House Labor and Commerce Committee
House of Representatives
P.O. Box V
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I hope that this letter and the attached premium schedule better answers your questions. If you have any further questions, please feel free to call me.

Sincerely,

Mary A. Pierce
Executive Director

MAP/blb

Enclosure

MICA

Medical Indemnity
Corporation of Alaska

ALEUT PLAZA OFFICE BUILDING
4000 OLD SEWARD HIGHWAY, SUITE 203
ANCHORAGE, ALASKA 99503
TELEPHONE (907) 563-3414

1990

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

PROFESSIONAL LIABILITY COVERAGES

Explanation of Policy:

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

MICA's premium rates are derived from the historical pattern of reported claims resulting from the performance of professional services which form a "stair step" with an increasing number of claims being reported each year until the fifth year. In the first year, only about 19 % of the total claims resulting from professional services are reported; the second 39 %; the third 78 %; the fourth 93 %; the fifth and subsequent years, about 100 %.

Cost:

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

All policies issued by MICA are renewed on January 1 of each year. Your first years and renewal rates are pro-rated from the first date of coverage (inception date) of the original policy. For example, if your continuous coverage became effective on July 1, 1986, your annual renewal premium on January 1, 1990 would be pro-rated from January 1 through June 30 on the fourth year rates and from July 1 through December 31 on the fifth year rates.

Limits of Liability:

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

$200,000 per occurrence/$600,000 aggregate per calendar year.
$500,000 per occurrence/$1,000,000 aggregate per calendar year.
$1,000,000 per occurrence/$2,000,000 aggregate per calendar year.
$1,000,000 per occurrence/$3,000,000 aggregate per calendar year.

Reporting Endorsement (Tail Coverage) *

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

"Tail" coverage must also be recognized when a physician reduces rating classification to offset reduced premium charges while subsequently reported claims from the higher specialty continues to occur. This is currently being accomplishedby charging "tail" premium on a pro-rata basis as between the two speciality classes when the policy is ultimately terminated.

Cost:

The cost of "tail" coverage will depend upon the length of time you have been insured with MICA, limits of liability purchased, physician's rating class and will be subject to the company's rules, rates, and rating plans in effect at the time the Unlimited Reporting Endorsement is requested.

* The policy limits purchased for the Unlimited Reporting endorsement will be applicable just as if the policy had not been cancelled or terminated and all subsequently reported claims had been reported during the last policy year.

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

Retirement Benefit:

An Unlimited Reporting Endorsement (tail coverage) will be issued at no extra cost to any physician who has attained the age and years in the MICA program (as per the schedule below) and having completed five consecutive years as a MICA insured just prior to retirement:**

Age	Years as MICA Insured
60	5
59	6
58	7
57	8
56	9
55	10

**** Retirement is defined as totally ceasing the private practice of medicine. A limited or parttime practice is not considered retirement.**

Death or Total and Permanent Disability:

A Reporting Endorsement (tail coverage) will be issued at no extra cost because of death or permanent total disability, i.e., unable to continue the practice of medicine in any limited or modified capacity.

New Doctor Rule:

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

Claims Free Premium Discount:

A 20 % premium discount will be provided to our insured physicians for a five year claims free history. This policyholder benefit will be provided upon renewal following the completion of the fifth year in which a claims free record has been demonstrated.

Claims Experience Premium Surcharges:

Claims experience premium surcharges may be imposed upon insureds with two or more claims in the last three years in which some elements of negligence or other contributing adverse factors are involved.

Employee Coverages:

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

Employee premium charges are limited to: (1) Advanced Nurse Practitioners or Physician's Assistants added to a physician's or clinic's policy subject to 50 % of Class 1 premium (shares policy limits with employer, sponsor or supervising physician); (2) Physician's Assistants or Nurse Practitioners on policies providing separate limits of liability from sponsoring/supervising physician, subject to higher premium based upon specialty and practice situation; (3) employed Nurse Midwives or directly supervised Certified Registered Nurse Anesthetists (CRNAs) are subject to 100 % Class 3 annual premium; (4) unsupervised CRNAs or Nurse Midwives are subject to 100 % of Class 4 and Class 4A premium respectively.

No additional premium charges are incurred for other employees.

Locum Tenens:

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

This coverage is limited to 6 separate periods per year (except for illness or family emergencies of the insured physician) and any additional periods will involve the customary premium charges for short-term practice situations (see next paragraph)

A negative factor in considering the acceptability of a locum tenens physician is the lack of current or recent professional liability insurance coverage on the applicant. This lack precludes verification of prior claims experience and other elements of insurability.

Short Term Practice Situations:

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

Part Time Practitioners:

Class 0, 1, 1-A, 2, 2-A and Family practitioners in any class: 35 % of the scheduled annual premiums for 10 hours or less per week practice; 65 % of the scheduled annual premium for 20 hours or less per week practice.

Comprehensive General Liability Coverages:

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

This coverage is limited to premises actually occupied by our insured in rendering professional services. For example, if an insured occupied one suite of a building, coverage would be limited to only that suite. An entire building cannot be covered under the Comprehensive General Liability Endorsement unless the insured or the insured's employees occupy the entire building in the rendering of medical services.

Corporate/Partnership/Group Professional Liability:

This optional coverage is available at no additional charge to solo practitioners and group practices, providing each member or employed physician carries coverage through the Company. The only requirement for group limits is that the limits of liability on the group may never be higher than the lowest limit carried by any member of the group. The separate limits of liability for the corporation/partnership/group does not apply to policyholders who are solo practitioners nor does it apply concurrently or on an excess basis to the physician (s) scheduled on the policy or associated with the same medical organization who also allegedly provide neligent patient care for the same occurrence.

This form provides individual limits of liability to each physician named on the policy schedule except these limits shall not be concurrent nor excess to the corporate limits of liability stated in the previous paragraph.

Optional Shared Limits Professional Liability Group Coverage:

This optional coverage is available through the Company for your group at reduced premium levels. (see discount schedule that follows). One master policy is issued with each associated or employed physician covered by endorsement.

Coverages are limited to the course and scope of employment or association with your group. **The combined clinic/group insureds are subject to the single limits of liability per occurrence and annual aggregate limits as procured.**

Completion of the Physician's and Surgeon's Professional Liability Group Application is required, along with completion of individual application for each physician to be insured.

Discounts Per Limits of Liability

# Doctors on Policy	$500,000	$1,000,000
1	0	0
2	9%	7%
3	11%	9%
4	12%	10%
5	13%	11%
6	14%	12%
7	15%	13%
8	16%	14%
9+	17%	15%

Installments - Deferred Payments:

Initial policy issuance subject to deposit of $1,000 or two month's annual premium. Deferred payments are available in quarterly or semi-annual installments payable: 35%, 25 %, 25 % and 15 % quarterly or 60 % and 40 % semi-annually. Premium invoices should be paid upon receipt and the policy is subject to immediate cancellation if payment is not received by the first day of the quarter in which the premium is earned. Carrying charges are computed at 10 % annual simple interest on the unpaid balance.

The full premium for an Unlimited Reporting Endorsement must be received by the company within twelve months following its inception date. The Unlimited Reporting Endorsement will be cancelled at the end of this twelve month period if the full premium has not been received at that time, and only premium earned for this twelve month Reporting Endorsement period will be charged in accordance with rates actuarially determined and filed with the Division of Insurance.

PHYSICIAN'S RATE CLASSIFICATIONS

Class 0
Psychiatry - Excluding ECT
Pathology

Class 1
Neurology
Physicians - no surgery
Applies to general practitioners and physician specialists who do not perform obstetrical procedures or major / minor surgery (other than incision of boils and superficial abscesses, suturing of skin and superficial fascia or neonate circumcision) who do not ordinarily assist in major surgical procedures.

Class 1-A
General Practitioners assisting at surgery (own patients only)
Opthalmology (excluding Radial Karatotomy)

Class 2
Physicians - minor surgery or assisting in major surgery*
Applies to general practitioners and physician specialists who perform minor surgery or assist in major surgery.
Neonatology
Cardiology

Class 2-A
Emergency Medicine
Therapeutic Radiology

Class 2-C
Urology

Class 3
Physicians - major surgery *
Physicians who include obstetrical procedures as any part of their practice.
Proctology
Otorhinolaryngology
Abdominal Surgery
General Surgery
Pediatric Surgery
Thoracic Surgery
Traumatic Surgery
Plastic and Reconstructive Surgery (excluding cosmetic surgery)
Urology
Gynecology (No Obstetrics)

Class 4
Anesthesiology

Class 4-A
Physicians - major surgery *
Obstetrics - Gynecology
Cardiovascular Surgery
Hand Surgery
Plastic and Reconstructive Surgery (including cosmetic surgery)
Vascular Surgery
Orthopedic Surgery (excluding total joint procedures spinal surgery and insertion of prosthetic devices)

Class 5
Physicians - major surgery*
Neurosurgery
Orthopedic Surgery (including total joint procedures, spinal surgery and insertion of prosthetic devices)

***Major Surgery** -involves operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis, or any other operation that presents a distinct hazard to life becasue of the condition of a patient or the length or circumstances of an operation. It also includes removal of tumors (except skin tumors), open bone fractures, amputations, abortions, removal of any gland or organ, plastic surgery and any operations using general anesthesia.

NOTE: IF A PORTION OF THE PHYSICIANS PRACTICE IS IN A SPECIALITY WITH A HIGHER CLASS THAN HIS NORMAL SPECIALTY, HE OR SHE MAY BE PLACED IN THE HIGHER SPECIALTY FOR RATING PURPOSES.

CLAIMS - MADE PREMIUM SCHEDULE

Effective January 1, 1990

LIMITS OF LIABILITY: EACH CLAIM AND ANNUAL AGGREGATE

	1st - 5th Years	$200,000/$600,000	$500,000/$1,000,000	$1,000,000/$2,000,000 $1,000,000/$3,000,000 *
CLASS 0				
1st year rates	Jan. 1, 1990	2,924	3,182	3,601
• 2nd year renewal rates	Jan. 1, 1989	3,467	4,026	4,857
• 3rd year renewal rates	Jan. 1, 1988	4,559	5,607	7,119
• 4th year renewal rates	Jan. 1, 1987	5,026	6,271	8,058
• 5th year renewal rates	Jan. 1, 1986	5,177	6,485	8,361
CLASS 1				
1st year rates	Jan. 1, 1990	3,798	4,305	5,067
• 2nd year renewal rates	Jan. 1, 1989	4,828	5,809	7,230
• 3rd year renewal rates	Jan. 1, 1988	6,724	8,497	11,031
• 4th year renewal rates	Jan. 1, 1987	7,517	9,612	12,599
• 5th year renewal rates	Jan. 1, 1986	7,772	9,970	13,103
CLASS 1-A				
1st year rates	Jan. 1, 1990	4,548	5,270	6,326
• 2nd year renewal rates	Jan. 1, 1989	5,997	7,341	9,268
• 3rd year renewal rates	Jan. 1, 1988	8,584	10,980	14,391
• 4th year renewal rates	Jan. 1, 1987	9,657	12,482	16,499
• 5th year renewal rates	Jan. 1, 1986	10,001	12,964	17,176
CLASS 2				
1st year rates	Jan. 1, 1990	5,338	6,286	7,651
• 2nd year renewal rates	Jan. 1, 1989	7,228	8,953	11,414
• 3rd year renewal rates	Jan. 1, 1988	10,542	13,593	17,928
• 4th year renewal rates	Jan. 1, 1987	11,909	15,503	20,605
• 5th year renewal rates	Jan. 1, 1986	12,348	16,116	21,464
CLASS 2-A				
1st year rates	Jan. 1, 1990	7,098	8,550	10,605
• 2nd year renewal rates	Jan. 1, 1989	9,971	12,547	16,196
• 3rd year renewal rates	Jan. 1, 1988	14,905	19,417	25,811
• 4th year renewal rates	Jan. 1, 1987	16,928	22,235	29,755
• 5th year renewal rates	Jan. 1, 1986	17,577	23,139	31,020
CLASS 2-B				
1st year rates	Jan. 1, 1990	8,857	10,813	13,558
• 2nd year renewal rates	Jan. 1, 1989	12,713	16,140	20,978
• 3rd year renewal rates	Jan. 1, 1988	19,268	25,241	33,693
• 4th year renewal rates	Jan. 1, 1987	21,948	28,967	38,904
• 5th year renewal rates	Jan. 1, 1986	22,807	30,162	40,576

* PREMIUM COST IS 4% ABOVE $1,000,000./$2,000,000. LIMITS.

Claims-made premium prepared by Milliman & Robertson, Inc., consulting Actuaries for the Medical Indemnity Corporation of Alaska, are based on a five year pricing step for reported claims adjusted annually for claims experience.

•Retroactive dates and renewal premium apply to 2nd through 5th year annual renewal. First year physicians are subject to first year rates.

•All policies are renewed each year on January 1. All 1st and renewal premiums are pro-rated subject to the first day of coverage under the original policy.

CLAIMS - MADE PREMIUM SCHEDULE

Effective January 1, 1990

LIMITS OF LIABILITY: EACH CLAIM AND ANNUAL AGGREGATE

	1st - 5th Years	$200,000/$600,000	$500,000/$1,000,000	$1,000,000/$2,000,000 $1,000,000/$3,000,000 *
CLASS 2-C				
1st year rates	Jan. 1, 1990	8,294	10,089	12,613
• 2nd year renewal rates	Jan. 1, 1989	11,836	14,991	19,448
• 3rd year renewal rates	Jan. 1, 1988	17,872	23,377	31,171
• 4th year renewal rates	Jan. 1, 1987	20,342	26,813	35,976
• 5th year renewal rates	Jan. 1, 1986	21,133	27,915	37,518
CLASS 3				
1st year rates	Jan. 1, 1990	8,857	10,813	13,558
• 2nd year renewal rates	Jan. 1, 1989	12,713	16,140	20,978
• 3rd year renewal rates	Jan. 1, 1988	19,268	25,241	33,693
• 4th year renewal rates	Jan. 1, 1987	21,948	28,967	38,904
• 5th year renewal rates	Jan. 1, 1986	22,807	30,162	40,576
CLASS 4				
1st year rates	Jan. 1, 1990	11,218	13,850	17,520
• 2nd year renewal rates	Jan. 1, 1989	16,392	20,960	27,392
• 3rd year renewal rates	Jan. 1, 1988	25,120	33,052	44,266
• 4th year renewal rates	Jan. 1, 1987	28,680	37,997	51,176
• 5th year renewal rates	Jan. 1, 1986	29,821	39,582	53,393
CLASS 4-A				
1st year rates	Jan. 1, 1990	14,140	17,608	22,422
• 2nd year renewal rates	Jan. 1, 1989	20,944	26,926	35,330
• 3rd year renewal rates	Jan. 1, 1988	32,362	42,720	57,351
• 4th year renewal rates	Jan. 1, 1987	37,012	49,172	66,365
• 5th year renewal rates	Jan. 1, 1986	38,502	51,241	69,255
CLASS 5				
1st year rates	Jan. 1, 1990	19,199	24,116	30,914
• 2nd year renewal rates	Jan. 1, 1989	28,829	37,257	49,079
• 3rd year renewal rates	Jan. 1, 1988	44,906	59,463	80,014
• 4th year renewal rates	Jan. 1, 1987	51,443	68,528	92,670
• 5th year renewal rates	Jan. 1, 1986	53,536	71,433	96,729

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Claims-made premium prepared by Milliman & Robertson, Inc., consulting Actuaries for the Medical Indemnity Corporation of Alaska, are based on a five year pricing step for reported claims adjusted annually for claims experience.

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•All policies are renewed each year on January 1. All 1st and renewal premiums are pro-rated subject to the first day of coverage under the original policy.

MICA

Medical Indemnity
Corporation of Alaska

ALEUT PLAZA OFFICE BUILDING
4000 OLD SEWARD HIGHWAY, SUITE 203
ANCHORAGE, ALASKA 99503
TELEPHONE (907) 563-3414

1990

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

PROFESSIONAL LIABILITY COVERAGES

Explanation of Policy:

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

MICA's premium rates are derived from the historical pattern of reported claims resulting from the performance of professional services which form a "stair step" with an increasing number of claims being reported each year until the fifth year. In the first year, only about 19 % of the total claims resulting from professional services are reported; the second 39 %; the third 78 %; the fourth 93 %; the fifth and subsequent years, about 100 %.

Cost:

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

All policies issued by MICA are renewed on January 1 of each year. Your first years and renewal rates are pro-rated from the first date of coverage (inception date) of the original policy. For example, if your continuous coverage became effective on July 1, 1986, your annual renewal premium on January 1, 1990 would be pro-rated from January 1 through June 30 on the fourth year rates and from July 1 through December 31 on the fifth year rates.

Limits of Liability:

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

$200,000 per occurrence/$600,000 aggregate per calendar year.
$500,000 per occurrence/$1,000,000 aggregate per calendar year.
$1,000,000 per occurrence/$2,000,000 aggregate per calendar year.
$1,000,000 per occurrence/$3,000,000 aggregate per calendar year.

Reporting Endorsement (Tail Coverage) *

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

"Tail" coverage must also be recognized when a physician reduces rating classification to offset reduced premium charges while subsequently reported claims from the higher specialty continues to occur. This is currently being accomplishedby charging "tail" premium on a pro-rata basis as between the two speciality classes when the policy is ultimately terminated.

Cost:

The cost of "tail" coverage will depend upon the length of time you have been insured with MICA. limits of liability purchased, physician's rating class and will be subject to the company's rules, rates, and rating plans in effect at the time the Unlimited Reporting Endorsement is requested.

*** The policy limits purchased for the Unlimited Reporting endorsement will be applicable just as if the policy had not been cancelled or terminated and all subsequently reported claims had been reported during the last policy year.**

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

Retirement Benefit:

An Unlimited Reporting Endorsement (tail coverage) will be issued at no extra cost to any physician who has attained the age and years in the MICA program (as per the schedule below) and having completed five consecutive years as a MICA insured just prior to retirement:**

Age	Years as MICA Insured
60	5
59	6
58	7
57	8
56	9
55	10

**** Retirement is defined as totally ceasing the private practice of medicine. A limited or parttime practice is not considered retirement.**

Death or Total and Permanent Disability:

A Reporting Endorsement (tail coverage) will be issued at no extra cost because of death or permanent total disability, i.e., unable to continue the practice of medicine in any limited or modified capacity.

New Doctor Rule:

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

Claims Free Premium Discount:

A 20 % premium discount will be provided to our insured physicians for a five year claims free history. This policyholder benefit will be provided upon renewal following the completion of the fifth year in which a claims free record has been demonstrated.

Claims Experience Premium Surcharges:

Claims experience premium surcharges may be imposed upon insureds with two or more claims in the last three years in which some elements of negligence or other contributing adverse factors are involved.

Employee Coverages:

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

Employee premium charges are limited to: (1) Advanced Nurse Practitioners or Physician's Assistants added to a physician's or clinic's policy subject to 50 % of Class 1 premium (shares policy limits with employer, sponsor or supervising physician); (2) Physician's Assistants or Nurse Practitioners on policies providing separate limits of liability from sponsoring/supervising physician, subject to higher premium based upon specialty and practice situation; (3) employed Nurse Midwives or directly supervised Certified Registered Nurse Anesthetists (CRNAs) are subject to 100 % Class 3 annual premium; (4) unsupervised CRNAs or Nurse Midwives are subject to 100 % of Class 4 and Class 4A premium respectively.

No additional premium charges are incurred for other employees.

Locum Tenens:

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

This coverage is limited to 6 separate periods per year (except for illness or family emergencies of the insured physician) and any additional periods will involve the customary premium charges for short-term practice situations (see next paragraph)

A negative factor in considering the acceptability of a locum tenens physician is the lack of current or recent professional liability insurance coverage on the applicant. This lack precludes verification of prior claims experience and other elements of insurability.

Short Term Practice Situations:

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

Part Time Practitioners:

Class 0, 1, 1-A, 2, 2-A and Family practitioners in any class: 35 % of the scheduled annual premiums for 10 hours or less per week practice; 65 % of the scheduled annual premium for 20 hours or less per week practice.

Comprehensive General Liability Coverages:

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

This coverage is limited to premises actually occupied by our insured in rendering professional services. For example, if an insured occupied one suite of a building, coverage would be limited to only that suite. An entire building cannot be covered under the Comprehensive General Liability Endorsement unless the insured or the insured's employees occupy the entire building in the rendering of medical services.

Corporate/Partnership/Group Professional Liability:

This optional coverage is available at no additional charge to solo practitioners and group practices, providing each member or employed physician carries coverage through the Company. The only requirement for group limits is that the limits of liability on the group may never be higher than the lowest limit carried by any member of the group. The separate limits of liability for the corporation/partnership/group does not apply to policyholders who are solo practitioners nor does it apply concurrently or on an excess basis to the physician (s) scheduled on the policy or associated with the same medical organization who also allegedly provide neligent patient care for the same occurrence.

This form provides individual limits of liability to each physician named on the policy schedule except these limits shall not be concurrent nor excess to the corporate limits of liability stated in the previous paragraph.

Optional Shared Limits Professional Liability Group Coverage:

This optional coverage is available through the Company for your group at reduced premium levels. (see discount schedule that follows). One master policy is issued with each associated or employed physician covered by endorsement.

Coverages are limited to the course and scope of employment or association with your group. **The combined clinic/group insureds are subject to the single limits of liability per occurrence and annual aggregate limits as procured.**

Completion of the Physician's and Surgeon's Professional Liability Group Application is required, along with completion of individual application for each physician to be insured.

Discounts Per Limits of Liability

# Doctors on Policy	$500,000	$1,000,000
1	0	0
2	9%	7%
3	11%	9%
4	12%	10%
5	13%	11%
6	14%	12%
7	15%	13%
8	16%	14%
9+	17%	15%

Installments - Deferred Payments:

Initial policy issuance subject to deposit of $1,000 or two month's annual premium. Deferred payments are available in quarterly or semi-annual installments payable: 35%, 25 %, 25 % and 15 % quarterly or 60 % and 40 % semi-annually. Premium invoices should be paid upon receipt and the policy is subject to immediate cancellation if payment is not received by the first day of the quarter in which the premium is earned. Carrying charges are computed at 10 % annual simple interest on the unpaid balance.

The full premium for an Unlimited Reporting Endorsement must be received by the company within twelve months following its inception date. The Unlimited Reporting Endorsement will be cancelled at the end of this twelve month period if the full premium has not been received at that time, and only premium earned for this twelve month Reporting Endorsement period will be charged in accordance with rates actuarially determined and filed with the Division of Insurance.

PHYSICIAN'S RATE CLASSIFICATIONS

Class 0
Psychiatry - Excluding ECT
Pathology

Class 1
Neurology
Physicians - no surgery
Applies to general practitioners and physician specialists who do not perform obstetrical procedures or major / minor surgery (other than incision of boils and superficial abscesses, suturing of skin and superficial fascia or neonate circumcision) who do not ordinarily assist in major surgical procedures.

Class 1-A
General Practitioners assisting at surgery (own patients only)
Opthalmology (excluding Radial Karatotomy)

Class 2
Physicians - minor surgery or assisting in major surgery*
Applies to general practitioners and physician specialists who perform minor surgery or assist in major surgery.
Neonatology
Cardiology

Class 2-A
Emergency Medicine
Therapeutic Radiology

Class 2-C
Urology

Class 3
Physicians - major surgery *
Physicians who include obstetrical procedures as any part of their practice.
Proctology
Otorhinolaryngology
Abdominal Surgery
General Surgery
Pediatric Surgery
Thoracic Surgery
Traumatic Surgery
Plastic and Reconstructrive Surgery (excluding cosmetic surgery)
Urology
Gynecology (No Obstetrics)

Class 4
Anesthesiology

Class 4-A
Physicians - major surgery *
Obstetrics - Gynecology
Cardiovascular Surgery
Hand Surgery
Plastic and Reconstructive Surgery (including cosmetic surgery)
Vascular Surgery
Orthopedic Surgery (excluding total joint procedures spinal surgery and insertion of prosthetic devices)

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Physicians - major surgery*
Neurosurgery
Orthopedic Surgery (including total joint procedures, spinal surgery and insertion of prosthetic devices)

*Major Surgery -involves operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis, or any other operation that presents a distinct hazard to life becasue of the condition of a patient or the length or circumstances of an operation. It also includes removal of tumors (except skin tumors), open bone fractures, amputations, abortions, removal of any gland or organ, plastic surgery and any operations using general anesthesia.

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CLAIMS - MADE PREMIUM SCHEDULE

Effective January 1, 1990

LIMITS OF LIABILITY: EACH CLAIM AND ANNUAL AGGREGATE

	1st - 5th Years	$200,000/$600,000	$500,000/$1,000,000	$1,000,000/$2,000,000 $1,000,000/$3,000,000 *
CLASS 0				
1st year rates	Jan. 1, 1990	2,924	3,182	3,601
• 2nd year renewal rates	Jan. 1, 1989	3,467	4,026	4,857
• 3rd year renewal rates	Jan. 1, 1988	4,559	5,607	7,119
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Effective January 1, 1990

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• 2nd year renewal rates	Jan. 1, 1989	11,836	14,991	19,448
• 3rd year renewal rates	Jan. 1, 1988	17,872	23,377	31,171
• 4th year renewal rates	Jan. 1, 1987	20,342	27,813	35,976
• 5th year renewal rates	Jan. 1, 1986	21,133	27,915	37,518
CLASS 3				
1st year rates	Jan. 1, 1990	8,857	10,813	13,558
• 2nd year renewal rates	Jan. 1, 1989	12,713	16,140	20,978
• 3rd year renewal rates	Jan. 1, 1988	19,268	25,241	33,693
• 4th year renewal rates	Jan. 1, 1987	21,948	28,967	38,904
• 5th year renewal rates	Jan. 1, 1986	22,807	30,162	40,576
CLASS 4				
1st year rates	Jan. 1, 1990	11,211	13,850	17,520
• 2nd year renewal rates	Jan. 1, 1989	16,392	20,960	27,392
• 3rd year renewal rates	Jan. 1, 1988	25,120	33,052	44,266
• 4th year renewal rates	Jan. 1, 1987	28,680	37,997	51,176
• 5th year renewal rates	Jan. 1, 1986	29,821	39,582	53,393
CLASS 4-A				
1st year rates	Jan. 1, 1990	14,140	17,608	22,422
• 2nd year renewal rates	Jan. 1, 1989	20,944	26,926	35,330
• 3rd year renewal rates	Jan. 1, 1988	32,362	42,720	57,351
• 4th year renewal rates	Jan. 1, 1987	37,012	49,172	66,365
• 5th year renewal rates	Jan. 1, 1986	38,502	51,241	69,255
CLASS 5				
1st year rates	Jan. 1, 1990	19,199	24,116	30,914
• 2nd year renewal rates	Jan. 1, 1989	28,829	37,257	49,079
• 3rd year renewal rates	Jan. 1, 1988	44,906	59,463	80,014
• 4th year renewal rates	Jan. 1, 1987	51,443	68,528	92,670
• 5th year renewal rates	Jan. 1, 1986	53,536	71,433	96,729

* PREMIUM COST IS 4% ABOVE $1,000,000/$2,000,000 LIMITS

Claims-made premium prepared by Milliman & Robertson, Inc., consulting Actuaries for the Medical Indemnity Corporation of Alaska, are based on a five year pricing step for reported claims adjusted annually for claims experience.

•Retroactive dates and renewal premium apply to 2nd through 5th year annual renewal. First year physicians are subject to first year rates.

•All policies are renewed each year on January 1. All 1st and renewal premiums are pro-rated subject to the first day of coverage under the original policy.

RATE CHANGES	M.D.	HOSPITAL
1981	+ 2.5%	- 6.0%
1982	+ 5.0%	+ 5.0%
1983	- 6.5%	+20.0%
1984	+ 7.5%	+ 7.5%
1985	+15.0% *	+15.)%
1986	+90.0% **	+107.%
1987	+25.0%	+42.0%
1988	+23.0%	0%
1989	0%	0%
1990	- 8.0%	- 5.0%

* Some specialties had class change providing larger increases:
Examples:
Family Practice doing O.B. + 86% (Changed to Class 2B)
Emergency Medicine + 66% (Changed to Class 2A)

** Increase for 1M/2M limits were greater (approximately 125%)

April 19, 1989

Mary Pierce, Executive Director
Medical Indemnity Corporation of Alaska
Aleut Plaza Office Building
4000 Old Seward Highway, Suite 203
Anchorage, Alaska 99503

Dear Ms. Pierce:

The State of Alaska Division of Public Health recently conducted a survey of the OB-GYN's and family practice physicians in Alaska in order to determine the effects of the current medical malpractice atmosphere on their decision whether to continue practicing obstetrics. In compiling a report on the survey results, I would very much like to include information from your organization concerning actual claims. I feel this information would contribute greatly to a balanced analysis of the medical malpractice situation in Alaska.

I have spoken with Jan Johnston, who gave me background information on MICA and helped me to refine my data request. My hope is that this information can be accessed relatively easily via computer. Please disregard any parts of this request that would require a major effort on the part of your staff. If a substantial amount of this information already exists in the form of an annual report or other prepared report, I will gladly accept a copy of these documents in lieu of a special computer run. Ideally, I'd like to complete my report by the end of April.

My questions are the following:

1. How many obstetrics-related claims has your agency processed each year from 1980 through 1988? Include both formal claims and filed suits in this total. I am interested in the year the incident was reported rather than the year of its occurrence, and would like to know what percentage of each year's claims resulted in a settlement with the claimant (do not include those which were successfully defended).

2. What is MICA's average settlement cost (as well as the median and the mode, if available) for obstetrics claims for each year from 1980 through 1988? If possible, I would like averages for both the amount paid to the claimant and the total expenses of the agency, including those cases in which the claimant receives nothing. If you normally categorize obstetrics claims in some way (such as by diagnostic categories), I am interested in knowing the average settlement amount for each type of claim.

3. How many physicians are insured by MICA for obstetrics practice in 1989, and how many of those currently insured have ever had a claim filed against them during the time they were insured by your agency?

4. For the years 1980 through 1988, what percentage of the physicians you insured each year had claims filed against them during that year?

Thank you very much for your assistance. If you have questions about this request or about the survey, please call me at 465-3100. I will be sure to send you a copy of the report on the medical malpractice survey as soon as it is completed.

Sincerely,

MaryAnn VandeCastle

MaryAnn VandeCastle
Health Planner

State of Alaska Dept. of Health & Social Services
Division of Public Health
Section of Maternal, Child, and Family Health
Box H-06B
Juneau, AK 99811

FAX #: 586-1877

MICA Medical Indemnity Corporation of Alaska
ALEUT PLAZA
4000 OLD SEWARD HWY., SUITE 203
ANCHORAGE, ALASKA 99503
(907) 563-3414

May 3, 1989

State of Alaska Department of
Health & Social Services
Division of Public Health
Section of Maternal, Child, and Family Health
Box H-06B
Juneau, Alaska 99811

ATTN: Mary Ann VandeCastle
Health Planner

RE: Survey of OB/GYN's and Family Practitioners doing O.B.

Dear Ms. VandeCastle:

This will serve as a response to your letter of 4/19/89.

As I indicated in our telephone conversation, MICA has only recently computerized its policyholder data and also as a result of changing specialty designations, it is virtually impossible to accurately pick up prior year figures on the number of insureds actually doing obstetrics except by manually going through each policy file.

However, in 1988 MICA insured 15 OB/GYN's and 53 Family Practitioners doing obstetrics but in 1989, about one third of the OB/GYN's dropped their insurance and are now going "bare".

I understand that our Claims Manager, Jan Johnston, has responded under separate cover to the remainder of your inquiry regarding obstetrically related claims or suits filed against these specialties.

Please let me know if MICA can be of further assistance.

Very truly yours,

Art Stamford
Underwriting Manager

AS/tmb/SADHS.5/3

MICA Medical Indemnity Corporation of Alaska

ALEUT PLAZA
4000 OLD SEWARD HWY, SUITE 203
ANCHORAGE, ALASKA 99503
(907) 563-1414

April 27, 1989

MaryAnn VandeCastle
Health Planner
State of Alaska Department of Health and Social Services
Division of Public Health
Section and Maternal, Child, and Family Health
Box H-06B
Juneau, AK. 99811

Dear Ms. VandeCastle:

Mary Pierce has asked me to respond to your letter of April 19th. I am the Claims Manager at MICA and am the individual you spoke with at some length prior to submitting your written request to Ms. Pierce.

Items number three and four are presently being addressed by our Underwriting Department. Underwriting Manager, Art Stanford will probably send you a separate letter. Alternatively he may give his information to me and I will send it to you in a follow-up letter. At any rate, I have some information pulled together for you and didn't want to delay in getting it off since I realize you're working under some deadlines.

Attached, you will find a computer summary of all obstetrical claims "processed" between 1/1/80 and 12/31/88. For purposes of this study I presumed that any file closed prior to 1/1/80 was something not processed in the time frame in which you expressed an interest.

The computer sort provided lists only closed obstetrical files.

Column One: Indicates whether the claim is against a physician or hospital insured by MICA.

Column Two: I have obliterated the claim numbers for our own security purposes and because I don't think that you need them for purposes of your analysis.

Column Three:	Severity Code. 5 = case in litigation 4 = formal claim against the insureds' policy.
Column Four:	C = closed files and P = pending files.
Column Five:	Date of occurrence is the date on which the care in question was rendered.
Column Six:	Date of report is the date our insured reported the situation to MICA.
Column Seven:	Date closed equals the date our file was closed in this office.
Column Eight:	Indicates the total reserve change for indemnity over the life of the file.
Column Nine:	Indicates the total reserve change for loss adjustment expense over the life of the file.
Column Ten:	Indicates the actual indemnity payment to the patient, if any.
Column Eleven:	Indicates the final LAE (Loss Adjustment Expense) over the life of the file.

As you can see, referencing formal suits only, seven of the seventeen closed files resulted in no payment to the patient. Ten of the seventeen did result in an indemnity payment to the patient. Since you did not ask me to separate out whether the indemnity payment was a result of a voluntary settlement or a court judgment, I have not done so. You did not ask, but I thought you might be interested in knowing, that out of those seventeen closed lawsuits three involved Board Certified OB/GYN specialists; nine involved family practitioners doing obstetrics; and five involved hospitals. In every instance where a hospital was a co-defendant in an obstetrical suit there was also a physician co-defendant. The physicians were not always insured by MICA and sometimes were not insured at all.

Turning to the formal claims (severity code four) you will note that six of the fourteen concluded with no payment to the patient while eight resulted in an indemnity payment to the patient. You can assume that every case of payment was a voluntary settlement since the case was not in suit. One case involved the hospital; the other thirteen involved physicians. The thirteen physician claims were broken down as follows. Five were against OB/GYN specialists. Six were against family practitioners doing obstetrics. One was against an emergency room physician. One was against an Anesthesiologist.

There are three formal claims pending involving obstetrical matters that are not on the printout. These are all physician directed claims and all involve OB/GYN specialists.

After reviewing the information that you have requested in item one and two of your letter, I have decided it might be both easier and faster to provide you with the raw data and allow you to rearrange the numbers to suit your needs. I hope that meets with your approval.

You will note that I have not provided you with statistical data regarding the mean, mode, or average. The reason for this is twofold. First, the data base is not large enough to be creditable. Second, this information has to be compared with some separate parameters on long tail liability coverages like medical malpractice. You are free to extract those measurements from this raw data but I really don't think it has much statistical significance due to the small data base and the kind of business that we're talking about.

Another point of information. As I looked through our cases to extract obstetrically related ones, I made the decision to focus only on claims that really related to the later stages of pregnancy and labor and immediate post partum/neonatal period. There are a number of claims not included here against both obstetrical specialists and family practitioners doing obstetrics that derive from abortions, fertility care, ectopic pregnancies, etc. These are all situations that physicians who include obstetrics in their practice get into but I have not counted them as obstetrical claims. Likewise, on the other end of the conception-to-birth continuum I have excluded the number of claims against neonatologists and pediatricians who took care of babies who perhaps were born too early. No claim may have resulted for obstetrical management or, if a claim did involve the physician handling the obstetrical care, it is counted in the statistics I'm submitting to you. But some physician who ultimately took care of the baby may have been included in that claim and I have not included those files.

I guess the point I'm trying to make here is that the whole issue of reproduction is a very broad one and I have tried to limit my study to those case in which I thought you were most interested. But it doesn't really address the entire liability exposure that attends obstetrical and neonatal care.

I hope this information is of some help to you and invite you to contact me if I can clarify it in anyway.

Sincerely,

Janet Sican Johnston,
Claims Manager

JSJ/nlb

Enclosure

JOYSORT 4/26/89
CURRENT AS OF 3/31/89

P/H/R	CLAIM #	SEV.	STAT	D/O	D/R	DATE CLOSED	TOTAL RESERVE CHANGE ALL YEARS LOSS	LAE	TOTAL PAID ALL YEARS LOSS	LAE
M.D.		4	C	22-Jun-88	07-Apr-81	30-Jun-82	0.00	0.00	0.00	0.00
M.D.		4	C	23-Mar-82	08-Sep-82	30-Sep-83	100,000.00	3,935.75	100,000.00	3,935.75
M.D.		4	C	23-Mar-82	08-Sep-82	30-Sep-83	25,000.00	2,273.75	25,000.00	2,273.75
M.D.		4	C	07-Oct-83	01-Feb-84	23-Aug-84	7,883.18	1,110.00	7,883.18	1,110.00
M.D.		4	C	28-Nov-84	31-Jan-85	30-Jun-86	2,509.20	0.00	2,509.20	0.00
M.D.		4	C	08-Jun-84	05-Aug-84	30-Jun-86	831.80	0.00	831.80	0.00
M.L.		4	C	01-Sep-85	05-Dec-85	31-Mar-86	20,000.00	0.00	20,000.00	0.00
M.D.		4	C	30-Jul-85	25-Nov-85	16-Sep-87	0.20	0.00	0.20	0.00
M.L.		4	C	30-Jul-85	25-Nov-85	16-Sep-87	0.00	0.00	0.00	0.00
M.D.		4	C	30-Jul-85	25-Nov-85	16-Sep-87	0.00	0.00	0.00	0.00
M.D.		4	C	05-Jun-86	01-Jul-86	16-Dec-88	112,542.84	17,565.19	112,500.00	17,565.19
M.D.		4	C	17-Jul-86	05-Aug-86	10-Oct-86	5,935.83	0.00	5,935.83	0.00
M.D.		4	C	06-Nov-87	29-Dec-87	19-Dec-88	0.00	0.00	0.00	0.00
M.D.		4	C	21-Sep-84	14-Dec-87	19-Dec-88	0.00	0.00	0.00	0.00
							274,602.15	24,884.69	274,602.15	24,884.69

DATE 27-Apr-89

14 closed 6 w/out payment to pt.
8 with payment to pt.

M/Surg = 1
OB/Gyn 5
FP/OB 6
Other - ER = 1
Anes. 1

3 pending - not on printout
OB.

All MDs - all OB/Gyns.

X

REPORT 4/26/89
CURRENT AS OF 3/31/89

W/H/R	CLAIM #	SEV.	STAT	D/O	D/R	DATE CLOSED	TOTAL RESERVE CHARGE ALL YEARS LOSS	TOTAL RESERVE CHARGE ALL YEARS LAE	TOTAL PAID ALL YEARS LOSS	TOTAL PAID ALL YEARS LAE
M.D.		5	C	25-Jul-78	11-Feb-80	01-Aug-85	43,750.00	19,231.27	43,750.00	19,231.27
M.D.		5	C	03-Jul-79	26-Feb-80	30-Jun-87	75,000.00	4,056.74	75,000.00	4,056.74
M.D.		5	C	01-Jun-79	23-Feb-81	31-Mar-82	142,500.00	35,688.00	142,500.00	35,688.00
Wrsp		5	C	16-Apr-82	16-Apr-82	28 May-87	150,000.00	24,913.87	150,000.00	24,913.87
Wrsp		5	C	01-Sep-81	14-Apr-82	31-Dec-84	0.00	4,340.48	0.00	4,340.48
M.D.		5	C	16-Apr-82	16-Apr-82	28 May-87	150,000.00	21,933.11	150,000.00	21,933.11
Wrsp		5	C	19 Oct-81	23-Nov-83	31-Dec-84	0.00	6,393.41	0.00	6,393.41
M.D.		5	C	19-Dec-83	01-Mar-84	31 Dec 86	170,000.00	14,782.86	170,000.00	14,782.86
Wrsp		5	C	12-Dec-83	01-Mar-84	31-Dec-86	30,000.00	3,695.53	30,000.00	3,695.53
M.D.		5	C	01-Jul-83	01-Apr-84	12-Nov-86	0.00	7,676.81	0.00	7,676.81
M.D.		5	C	15-Feb-83	18-Feb-85	31-Mar-87	0.00	2,316.75	0.00	2,316.75
Wrsp		5	C	01-Sep-84	18-Mar-85	03-Jun-88	0.00	6,544.74	0.00	6,544.74
M.D.		5	C	01-Se	18-Mar-85	30-Jul-88	0.00	10,360.11	0.00	10,360.11
M.D.		5	C	19-Oc	31-Jul-85	30-Jun-88	2,200,000.00	13,846.84	2,200,000.00	13,846.84
M.D.		5	C	06-Jan-86	05-Feb-86	24-Mar-88	0.00	17,671.85	0.00	17,671.85
M.D.		5	C	29-Dec-82	02-Mar-87	30 Oct-89	49,357.50	2,433.60	49,357.50	2,433.60
M.D.		5	C	28-Feb-85	02-Mar-87	30-Oct-88	49,357.50	2,177.03	49,357.50	2,177.03
							3,059,965.00	197,511.86	3,059,965.00	197,511.86

DATE 27-Apr-89

14 closed — 4 w/out payment to pt.
10 with payment to pt

Wrsp = 5
OB.gyn = 3
FP/OB = 9

---

5 OB files pending - not in previous

Wrsp = 2
FP/OB = 2
Genl Surg = 1

MICA

Medical Indemnity
Corporation of Alaska

ALEUT PLAZA OFFICE BUILDING
4000 OLD SEWARD HIGHWAY, SUITE 203
ANCHORAGE, ALASKA 99503
TELEPHONE (907) 563-3414

1990

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

December 29, 1989

Representative Dave Donley, Chairman
House Labor and Commerce Committee
House of Representatives
P.O. Box V
Juneau, AK 99811

Dear Representative Donley:

The House Labor and Commerce Committee had hearings on November 30, 1989 at which time I was asked to have an "informal" chat with the committee. Since I wasn't prepared to testify, I gave you some estimated premium figures and promised to follow up with exact rate information.

MICA's 1990 Premium Schedule is enclosed for your information. The committee had asked me questions at the hearings specifically relating to the cost of insurance to physicians delivering babies. I mentioned that the majority of our phsician policyholders have limits $500,000 per claim, $1,000,000 aggregate. Physicians delivering babies are Class 3 on the schedule. Assuming a physician had policy limits of $500,000/1,000,000 and had been insured with MICA for five or more years his premium for 1990 would be $30,162. (This is about $20,000 less than I quoted to you.)

Another question is the difference in premium between a Family Practioner doing obstetrics and those who were not. Assuming the same scenerio as above and that the Family Practioner not doing obstetrics was doing minor surgery the difference would be $14,046. In other words, the Family Practioner who delivers babies pay $14,046 to do so (or about 1/2 of the total premium is for obstetrical coverage).

I hope that this letter and the attached premium schedule better answers your questions. If you have any further questions, please feel free to call me.

Sincerely,

Mary A. Pierce
Executive Director

MAP/blb

Enclosure

LIABILITY INSURANCE SURVEY

1. Do you now carry medical liability insurance? ____ Yes ____ No

   If yes, how long? _____

   With what carrier? _____

   If no, when did you cancel? _____

   Do you contemplate not carrying it in the near future, i.e. within the year? ___Yes ___No

   If you don't carry insurance: Is this a philosophical choice (i.e., you don't believe in it; if you don't have it you won't get sued, etc.) ____ Yes ____ No

   Is this economic, or because of other factors that have forced your choice? ___ Yes ___ No

2. What proportion, i.e. percent, of your net income is the medical liability premium?

3. What is your opinion as to a "fair" liability premium, as either an absolute dollar figure, or percent of gross, or percent of net?

4. Is there a level of premium that you would pay, i.e. what do you think you could afford?

5. Do you deliver babies? ____ Yes ____ No

   If yes, how many per year? _____

   What premium do you pay simply for obstetrics, in excess of your liability premium without obstetrics?

   _____

   If no, was the cost of malpractice liability a major factor? ____ Yes ____ No

6. If there was an affordable insurance as described above, would you then change to doing obstetrics?

Please verify the code in the top right hand corner of this survey (as noted in the accompanying letter) and return the survey in the enclosed envelope. Thank you.

Alaska State Medical Association

4107 Laurel Street Anchorage, Alaska 99508 (907) 562-2662 (Fax) 561-2063

December 29, 1989

Dear Colleague:

Enclosed is a survey intended to derive some needed information from Alaska physicians. As most of you know, the state medical association is taking a leadership role in trying to help the state legislature with the complicated issues surrounding tort reform and/or liability insurance. Before we can confront the legislature, we need factual data. This survey will help us gather the data regarding Alaska and match it with the larger picture of the nation and other nations of the world.

The information will be kept confidential. It is important that you realize that your name or even the coding will only be known to two or three members of the ASMA staff. Secondly, the information you provide should be flexible. You may add more data than is questioned. We want this information to be interactive so that you feel you have a part in deriving this survey. Make it as specific as you want to: give us your thoughts.

The code in the right hand corner is in three parts. The first part: G = Group, S = Solo (single practioner). The second part is the speciality code as designated by the American Medical Association. A copy of the list with codes is on the back of the survey form. The third part is location and that is: N = North, W = West, A = Anchorage, F = Fairbanks, SE = Southeast, and P = Kenai Peninsula. Please check the code to be sure that it does apply to you and to your practice.

I wish I could offer a prize or an incentive for completing this survey. The best I have to offer is our thanks and to tell you that you are taking part in some of the most important issues that we, as organized medicine, face today. Thank you for helping.

Cordially,

Russell A. Huffman, M.D.
President

RAH/jlw

Obstetricians

	Fewer than 10	10-20	21-40	41-100	101-200	over 200
Anchorage			1***	2	11	3
Kenai Peninsula				1		
Fairbanks					4	

*** This physician noted that he only does 40 deliveries because CNA (his carrier) increases the rates with an increase in deliveries.

The following are the statistics I testified to during the hearings.

Total: 321 Uninsured: 48 or 15%
187 of total doctors reside in Anchorage

	Delivering or Had Been Delivering Babies	Not Doing Deliveries
Total	131	190
Uninsured	27 or 20.6%	21 or 11%
Uninsured Located	14 - Anchorage	14 - Anchorage
	7 - Kenai Peninsula	4 - Kenai Peninsula
	2 - Fairbanks	3 - Southeast
	2 - North	
	2 - Southeast	
Stopped Coverage before 1987	6	9
% of Gross Income willing to Pay		
Minimum	5%	1%
Maximum	25%	10%
Average	10%	5-10%
No Longer Delivering Babies	42 * or 32%	

* - 33 doctors in the insured group were no longer delivering babies all due to cost.
- 9 doctors in the uninsured group were no longer delivering babies partially due to cost.

I hope this information proves useful. I've attached a copy of the questionnaire form that was distributed to the 616 private practice physician.

Sincerely,

Mary A. Pierce

Mary A. Pierce
Executive Director, MICA

MICA Medical Indemnity Corporation of Alaska

ALEUT PLAZA
4000 OLD SEWARD HWY., SUITE 203
ANCHORAGE, ALASKA 99503
(907) 563-3414

February 23, 1990

Representative David Donley, Chairman
House Labor and Commerce Committee
State of Alaska
P.O. Box V
Juneau, Alaska 99811

Dear Chairman Donley:

I was requested in a legislative hearing on Tuesday, February 20, to supply the committee with numbers of deliveries made per physician from information gathered on a questionnaire distributed by ASMA to private practice physicians in the state.

The information follows:

Family or General Practitioners doing Obstetrics

	Fewer than 10	10-20	21-40	41-100	101-200	over 200
Anchorage *		1	3	6		
Fairbanks		2	1			
Kenai Peninsula		2	2	3	1	
South East	1	3	6	3	1	
North				1 **		

* - Anchorage includes Mat-Su Valley

** - covered by Federal Government

General Surgeons (C-Section only)

	Fewer than 10	10-20	21-40	41-100	101-200	over 200
Southeast			1	1		

MICA Medical Indemnity Corporation of Alaska

ALEUT PLAZA
4000 OLD SEWARD HWY., SUITE 203
ANCHORAGE, ALASKA 99503
(907) 563-3414

April 2, 1990

Representative Peter Goll, Co-Chairman
House Judiciary Committee
House of Representatives
P..O. Box V
Juneau, AK 99811

Dear Representative Goll:

There were several questions from members of the Judiciary Committee regarding my testimony on March 29th. I felt that it might be helpful if, as a member of this committee, you received information answering all the questions.

First of all, I appreciate your interest in both MICA and your concern for the healthcare delivery system in the state. I have included information that might prove useful in understanding specific questions on how MICA does business and also, general information on physician demographics, specifically on those delivering babies.

Informational Items

1.) A letter to the House Labor and Commerce Committee. This provides information on where physicians practice, how many deliveries they do, and if they are insured. Included is a copy of the questionnaire that was distributed to the 614 private practice physicians in the state that we used to develop these statistics.

2.) Another letter to Representative Donley, a 1990 MICA premium schedule is enclosed.

3.) A schedule of rate changes since 1981.

4.) Response to questions about obstetrical claims to Department of Health and Social Services. This should answer all questions regarding loss experience.

Please let me know if I can provide you with other information that would prove useful.

Sincerely,

Mary A. Pierce

Mary A. Pierce
Executive Director

Part Time Practitioners:

Class 0, 1, 1-A, 2, 2-A and Family practitioners in any class: 35 % of the scheduled annual premiums for 10 hours or less per week practice; 65 % of the scheduled annual premium for 20 hours or less per week practice.

Comprehensive General Liability Coverages:

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

This coverage is limited to premises actually occupied by our insured in rendering professional services. For example, if an insured occupied one suite of a building, coverage would be limited to only that suite. An entire building cannot be covered under the Comprehensive General Liability Endorsement unless the insured or the insured's employees occupy the entire building in the rendering of medical services.

Corporate/Partnership/Group Professional Liability:

This optional coverage is available at no additional charge to solo practitioners and group practices, providing each member or employed physician carries coverage through the Company. The only requirement for group limits is that the limits of liability on the group may never be higher than the lowest limit carried by any member of the group. The separate limits of liability for the corporation/partnership/group does not apply to policyholders who are solo practitioners nor does it apply concurrently or on an excess basis to the physician (s) scheduled on the policy or associated with the same medical organization who also allegedly provide neligent patient care for the same occurrence.

This form provides individual limits of liability to each physician named on the policy schedule except these limits shall not be concurrent nor excess to the corporate limits of liability stated in the previous paragraph.

Optional Shared Limits Professional Liability Group Coverage:

This optional coverage is available through the Company for your group at reduced premium levels. (see discount schedule that follows). One master policy is issued with each associated or employed physician covered by endorsement.

Coverages are limited to the course and scope of employment or association with your group. **The combined clinic/group insureds are subject to the single limits of liability per occurrence and annual aggregate limits as procured.**

Completion of the Physician's and Surgeon's Professional Liability Group Application is required, along with completion of individual application for each physician to be insured.

Discounts Per Limits of Liability

# Doctors on Policy	$500,000	$1,000,000
1	0	0
2	9%	7%
3	11%	9%
4	12%	10%
5	13%	11%
6	14%	12%
7	15%	13%
8	16%	14%
9+	17%	15%

Installments - Deferred Payments:

Initial policy issuance subject to deposit of $1,000 or two month's annual premium. Deferred payments are available in quarterly or semi-annual installments payable: 35%, 25 %, 25 % and 15 % quarterly or 60 % and 40 % semi-annually. Premium invoices should be paid upon receipt and the policy is subject to immediate cancellation if payment is not received by the first day of the quarter in which the premium is earned. Carrying charges are computed at 10 % annual simple interest on the unpaid balance.

The full premium for an Unlimited Reporting Endorsement must be received by the company within twelve months following its inception date. The Unlimited Reporting Endorsement will be cancelled at the end of this twelve month period if the full premium has not been received at that time, and only premium earned for this twelve month Reporting Endorsement period will be charged in accordance with rates actuarially determined and filed with the Division of Insurance.

PROFESSIONAL LIABILITY COVERAGES

Explanation of Policy:

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

MICA's premium rates are derived from the historical pattern of reported claims resulting from the performance of professional services which form a "stair step" with an increasing number of claims being reported each year until the fifth year. In the first year, only about 19 % of the total claims resulting from professional services are reported; the second 39 %; the third 78 %; the fourth 93 %; the fifth and subsequent years, about 100 %.

Cost:

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

All policies issued by MICA are renewed on January 1 of each year. Your first years and renewal rates are pro-rated from the first date of coverage (inception date) of the original policy. For example, if your continuous coverage became effective on July 1, 1986, your annual renewal premium on January 1, 1990 would be pro-rated from January 1 through June 30 on the fourth year rates and from July 1 through December 31 on the fifth year rates.

Limits of Liability:

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

$200,000 per occurrence/$600,000 aggregate per calendar year.
$500,000 per occurrence/$1,000,000 aggregate per calendar year.
$1,000,000 per occurrence/$2,000,000 aggregate per calendar year.
$1,000,000 per occurrence/$3,000,000 aggregate per calendar year.

Reporting Endorsement (Tail Coverage) *

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

"Tail" coverage must also be recognized when a physician reduces rating classification to offset reduced premium charges while subsequently reported claims from the higher specialty continues to occur. This is currently being accomplishedby charging "tail" premium on a pro-rata basis as between the two speciality classes when the policy is ultimately terminated.

Cost:

The cost of "tail" coverage will depend upon the length of time you have been insured with MICA, limits of liability purchased, physician's rating class and will be subject to the company's rules, rates, and rating plans in effect at the time the Unlimited Reporting Endorsement is requested.

* The policy limits purchased for the Unlimited Reporting endorsement will be applicable just as if the policy had not been cancelled or terminated and all subsequently reported claims had been reported during the last policy year.

MICA

Medical Indemnity
Corporation of Alaska

ALEUT PLAZA OFFICE BUILDING
4000 OLD SEWARD HIGHWAY, SUITE 203
ANCHORAGE, ALASKA 99503
TELEPHONE (907) 563-3414

1990

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

December 29, 1989

Representative Dave Donley, Chairman
House Labor and Commerce Committee
House of Representatives
P.O. Box V
Juneau, AK 99811

Dear Representative Donley:

The House Labor and Commerce Committee had hearings on November 30, 1989 at which time I was asked to have an "informal" chat with the committee. Since I wasn't prepared to testify, I gave you some estimated premium figures and promised to follow up with exact rate information.

MICA's 1990 Premium Schedule is enclosed for your information. The committee had asked me questions at the hearings specifically relating to the cost of insurance to physicians delivering babies. I mentioned that the majority of our phsician policyholders have limits $500,000 per claim, $1,000,000 aggregate. Physicians delivering babies are Class 3 on the schedule. Assuming a physician had policy limits of $500,000/1,000,000 and had been insured with MICA for five or more years his premium for 1990 would be $30,162. (This is about $20,000 less than I quoted to you.)

Another question is the difference in premium between a Family Practioner doing obstetrics and those who were not. Assuming the same scenerio as above and that the Family Practioner not doing obstetrics was doing minor surgery the difference would be $14,046. In other words, the Family Practioner who delivers babies pay $14,046 to do so (or about 1/2 of the total premium is for obstetrical coverage).

I hope that this letter and the attached premium schedule better answers your questions. If you have any further questions, please feel free to call me.

Sincerely,

Mary A. Pierce
Executive Director

MAP/blb

Enclosure

LIABILITY INSURANCE SURVEY

1. Do you now carry medical liability insurance? ____ Yes ____ No

   If yes, how long? _____

   With what carrier? _____

   If no, when did you cancel? _____

   Do you contemplate not carrying it in the near future, i.e. within the year? ___Yes ___No

   If you don't carry insurance: Is this a philosophical choice (i.e., you don't believe in it; if you don't have it you won't get sued, etc.) ____ Yes ____ No

   Is this economic, or because of other factors that have forced your choice? ___ Yes ___ No

2. What proportion. i.e. percent, of your net income is the medical liability premium?

3. What is your opinion as to a "fair" liability premium, as either an absolute dollar figure, or percent of gross, or percent of net?

4. Is there a level of premium that you would pay, i.e. what do you think you could afford?

5. Do you deliver babies? ____. Yes ____ No

   If yes, how many per year? _____

   What premium do you pay simply for obstetrics, in excess of your liability premium without obstetrics?

   _____

   If no, was the cost of malpractice liability a major factor? ____ Yes ____ No

6. If there was an affordable insurance as described above, would you then change to doing obstetrics?

Please verify the code in the top right hand corner of this survey (as noted in the accomanying letter) and return the survey in the enclosed envelope. Thank you.

Alaska State Medical Association

4107 Laurel Street Anchorage, Alaska 99508 (907) 562-2662 (Fax) 561-2063

December 29, 1989

Dear Colleague:

Enclosed is a survey intended to derive some needed information from Alaska physicians. As most of you know, the state medical association is taking a leadership role in trying to help the state legislature with the complicated issues surrounding tort reform and/or liability insurance. Before we can confront the legislature, we need factual data. This survey will help us gather the data regarding Alaska and match it with the larger picture of the nation and other nations of the world.

The information will be kept confidential. It is important that you realize that your name or even the coding will only be known to two or three members of the ASMA staff. Secondly, the information you provide should be flexible. You may add more data than is questioned. We want this information to be interactive so that you feel you have a part in deriving this survey. Make it as specific as you want to: give us your thoughts.

The code in the right hand corner is in three parts. The first part: G = Group, S = Solo (single practioner). The second part is the speciality code as designated by the American Medical Association. A copy of the list with codes is on the back of the survey form. The third part is location and that is: N = North, W = West, A = Anchorage, F = Fairbanks, SE = Southeast, and P = Kenai Peninsula. Please check the code to be sure that it does apply to you and to your practice.

I wish I could offer a prize or an incentive for completing this survey. The best I have to offer is our thanks and to tell you that you are taking part in some of the most important issues that we, as organized medicine, face today. Thank you for helping.

Cordially,

Russell A. Huffman, Jr. M.D.
President

RAH/jlw

Obstetricians

	Fewer than 10	10-20	21-40	41-100	101-200	over 200
Anchorage			1***	2	11	3
Kenai Peninsula				1		
Fairbanks					4	

*** This physician noted that he only does 40 deliveries because CNA (his carrier) increases the rates with an increase in deliveries.

The following are the statistics I testified to during the hearings.

Total: 321 Uninsured: 48 or 15%
187 of total doctors reside in Anchorage

	Delivering or Had Been Delivering Babies	Not Doing Deliveries
Total	131	190
Uninsured	27 or 20.6%	21 or 11%
Uninsured Located	14 - Anchorage	14 - Anchorage
	7 - Kenai Peninsula	4 - Kenai Peninsula
	2 - Fairbanks	3 - Southeast
	2 - North	
	2 - Southeast	
Stopped Coverage before 1987	6	9
% of Gross Income willing to Pay		
Minimum	5%	1%
Maximum	25%	10%
Average	10%	5-10%
No Longer Delivering Babies	42 * or 32%	

* - 33 doctors in the insured group were no longer delivering babies all due to cost.
- 9 doctors in the uninsured group were no longer delivering babies partially due to cost.

I hope this information proves useful. I've attached a copy of the questionnaire form that was distributed to the 616 private practice physician.

Sincerely,

Mary A. Pierce

Mary A. Pierce
Executive Director, MICA

MICA Medical Indemnity Corporation of Alaska
ALEUT PLAZA
4000 OLD SEWARD HWY., SUITE 203
ANCHORAGE, ALASKA 99503
(907) 563-3414

February 23, 1990

Representative David Donley, Chairman
House Labor and Commerce Committee
State of Alaska
P.O. Box V
Juneau, Alaska 99811

Dear Chairman Donley:

I was requested in a legislative hearing on Tuesday, February 20, to supply the committee with numbers of deliveries made per physician from information gathered on a questionnaire distributed by ASMA to private practice physicians in the state.

The information follows:

Family or General Practitioners doing Obstetrics

	Fewer than 10	10-20	21-40	41-100	101-200	over 200
Anchorage *		1	3	6		
Fairbanks		4	1			
Kenai Peninsula		2	4	3	1	
South East	1	3	6	3	1	
North				1 **		

* - Anchorage includes Mat-Su Valley

** - covered by Federal Government

General Surgeons (C-Section only)

	Fewer than 10	10-20	21-40	41-100	101-200	over 200
Southeast			1	1		

MICA Medical Indemnity Corporation of Alaska

ALEUT PLAZA
4000 OLD SEWARD HWY., SUITE 203
ANCHORAGE, ALASKA 99503
(907) 563-3414

April 2, 1990

Representative Peter Goll, Co-Chairman
House Judiciary Committee
House of Representatives
P..O. Box V
Juneau, AK 99811

Dear Representative Goll:

There were several questions from members of the Judiciary Committee regarding my testimony on March 29th. I felt that it might be helpful if, as a member of this committee, you received information answering all the questions.

First of all, I appreciate your interest in both MICA and your concern for the healthcare delivery system in the state. I have included information that might prove useful in understanding specific questions on how MICA does business and also, general information on physician demographics, specifically on those delivering babies.

Informational Items

1.) A letter to the House Labor and Commerce Committee. This provides information on where physicians practice, how many deliveries they do, and if they are insured. Included is a copy of the questionnaire that was distributed to the 614 private practice physicians in the state that we used to develop these statistics.

2.) Another letter to Representative Donley, a 1990 MICA premium schedule is enclosed.

3.) A schedule of rate changes since 1981.

4.) Response to questions about obstetrical claims to Department of Health and Social Services. This should answer all questions regarding loss experience.

Please let me know if I can provide you with other information that would prove useful.

Sincerely,

Mary A. Pierce

Mary A. Pierce
Executive Director

AAT
Alaska Action Trust
P.O. Box 102323 • Anchorage, Alaska 99510
Office: 540 L Street, Suite 102 • Anchorage
(907) 258-4040

November 3, 1989

Representative Peter Goll
P. O. Box V
Juneau, Alaska 99811

Dear Representative Goll:

I would first like to introduce myself. I am Debra Gravo, the new executive director for the Alaska Academy of Trial Lawyers. I look forward to working with you during the upcoming legislative session.

Enclosed is a copy of the subsidy for rural obstetricians bill which Arizona Governor Mofford signed into law June 28, 1989. The bill has a rather interesting legislative history. The bill was introduced by an anti-tort reform legislator who lives in a rural country. While he strongly supported anti-reform, he felt that he had to do something to help the doctors in his district.

Sincerely,

Debra C. Gravo

Debra C. Gravo
Executive Director
dch/encl.

STATE OF MINNESOTA
DEPARTMENT OF COMMERCE
ST. PAUL 55101

OFFICE OF THE COMMISSIONER

500 METRO SQUARE BUILDING
ST. PAUL, MN 55101

February 8, 1989

Mr. Paul Roller
Director of Insurance
PO Box D
Juneau, Alaska 99811

Dear Director Roller:

I enclose a copy of a report recently issued by this Department regarding medical malpractice. The report reviews all claims filed with two insurers in Minnesota, North Dakota and South Dakota against physicians from January 1, 1982 until December 31, 1987. These two insurers composed the entire physician malpractice market in Minnesota. The report states as follows:

1. The frequency of physician malpractice claims has not measurably changed over the last six years.

2. The claims have not measurably changed in terms of the average claim payment.

3. Approximately 75% of all claims are closed without payment.

4. Insurers overestimate exposure of pending claims by at least two to three times the amount eventually paid.

5. Claims determined by insurer personnel to be frivolous did not increase.

6. The cost of investigation and defense of claims has not increased.

7. There were only 20 jury verdicts over the six-year period which were entered against a physician.

8. No punitive damages were found to be awarded against a physician.

The report concludes that in specialty markets insurers are able to raise premiums in a non-competitive manner primarily because:

1. Physicians are sold policies which do not insure claims made after the expiration of the policy year. As a result, if a physician attempts to switch insurers, they must purchase a second policy to cover future claims that occurred during the policy year. The second policy, a "tail endorsement," is expensive and creates a negative environment for competitive pricing.

2. Data concerning the frequency of claims or the severity of claims is not available to competitors. As a result, it is difficult for other insurers to price a policy.

3. The number of purchasers of speciality lines of insurance such as medical malpractice is not sufficient to generate substantial numbers of competing vendors. Insurers must insure large numbers of policyholders to spread risk, and that the limited number of policyholders in a niche makes it clear that new competitors would likely not survive market entry.

The report recommends that government agencies periodically examine and collect loss data in niche markets so that competing insurers will have credible data to use in determining whether competitive pricing exists.

The report has been examined by actuaries who verify its credibility. While the insurers acknowledge the accuracy of the raw data, the St. Paul Companies nonetheless has issued a critique of the report charging that it has flawed methodology.

If you have any questions on the report, please give me a call.

Very truly yours,

MICHAEL A. HATCH
Commissioner of Commerce

MAH:nl
Encl.

MEDICAL MALPRACTICE
CLAIM STUDY

1982 - 1987

MICHAEL A. HATCH, COMMISSIONER
MINNESOTA DEPARTMENT OF COMMERCE

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TABLES

I. INTRODUCTION

Raising the issue of "malpractice" in a room crowded with doctors, lawyers, consumer advocates, and insurance executives results in greater commotion than yelling "fire" in a crowded theater.

Unfortunately, the answers given to the many questions asked are different and conflicting. And everyone has their own statistical study to substantiate their answer. The only sure conclusion is a barrage of accusations and counter accusations that find the public and lawmakers caught in the crossfire. Tort reform? Insurance reform? Physician reform?

This report briefly reviews the history of medical malpractice claims in this country and the various proposals regarding malpractice coverage. The report further analyzes data collected during the Commerce Department's six month study of the two insurers who sell virtually 100 percent of the physician professional liability coverage in the State of Minnesota, the exception being self-insured groups. The two insurers are St. Paul Companies and Minnesota Medical Insurance Exchange (MMIE). During this time, the Department reviewed every individual claim filed with these two insurers over the last six years in the states of Minnesota, South Dakota and North Dakota - over 4,700 files.

It should be noted that, after reviewing this report, both the St. Paul Companies and MMIE asked that the Department clarify that the positions attributed to the insurance industry in this report do not necessarily reflect the individual views of St. Paul Companies or MMIE. Specifically, both companies stated, and the Department acknowledges, that they should not be identified as proponents of "tort reform." Further, MMIE stated that they know of no crisis in physicians and surgeons liability in Minnesota.

It should be emphasized that this report should not be construed as a critique of either insurer. The report is a critique or survey of the medical malpractice insurance market, and these insurers happen to comprise the market in Minnesota.

II. HISTORY

A. Medical Malpractice in the Seventies

Medical malpractice claims first appeared in significant numbers in the 1930's but did not attract much public attention until the late sixties and early seventies. In 1971, President Nixon created a Commission on Medical Malpractice to study the problem of increasing claim frequency. It's report was issued in 1973, about the same time that the medical malpractice insurance market began to experience its first crisis. The commission's findings concluded that the increase in medical malpractice litigation was due to a combination of more affordable and therefore widespread medical care and more complex medical procedures.

During the malpractice crisis of the mid seventies, many insurers raised their rates dramatically. Sky rocketing premiums became commonplace--50 percent, 100 percent, even 300 percent increases occurred in a single year. In addition, several large insurers withdrew from the medical malpractice market entirely, leading to a gap in availability of coverage. As a result, the problem escalated and became one of both affordability and availability.

In response to the crisis, legislatures around the country enacted measures aimed at curbing the effects of the crisis. Since insurers asserted that increased lawsuits caused unforeseen losses, legislation was primarily aimed at limiting the liability of health care providers. The various legislative attempts often included one or more of the following: 1) limits on attorney's contingency fees; 2) limits on non-economic damage awards, i.e. punitive damages; 3) revision of the statute of limitations; 4) creation of pretrial panels to screen cases to establish merit; 5) changes to collateral source rules; and 6) institution of periodic payment of judgments.

B. Joint Underwriting Associations:

In addition to these changes, two other significant changes resulted from the mid seventies crisis. The first was the creation of alternative markets - specifically joint underwriting associations (JUAs) and physician and hospital-sponsored nonprofit insurers or mutuals. A number of states enacted laws giving the insurance commissioner the power to establish a JUA at his or her discretion when warranted by market conditions. JUA's generally are comprised of all companies writing insurance in a particular state or all companies writing property/casualty insurance in a state and are controlled by a group of public and private sector representatives. The purpose of a JUA is to write liability insurance for health care providers who are unable to obtain coverage in the private market. In 1987, 13 medical malpractice JUA's were offering coverage to health care providers, including the Minnesota JUA. The market shares for the active JUA's ranged from 3 percent to 85 percent according to the National Coordinating Committee on Medical Malpractice JUAs.

The committee issued a report in 1987, the 1986 Financial Condition of Medical Malpractice JUAs, which found that five JUAs had insufficient funds to pay all existing claims liabilities. The greatest deficiency, reported in Massachusetts, was estimated to be $365.3 million. The report also found that the JUA market share had not changed significantly overall between 1985 and 1986, although the Florida, New York, and Wisconsin JUAs nearly doubled their respective market shares. It is apparent that those JUAs which incurred large deficits did so because of artificially low rates.

C. Physician Mutuals:

Physician/hospital mutuals, the second form of alternative malpractice market, first appeared in New York, Maryland and California in 1975. The creation of mutuals was based on the

premises: First, that a major influx of new insurers would alleviate the availability crisis and, secondly, that doctor-controlled nonprofit companies could issue affordable coverage to physicians in need. Nationwide in 1987, such mutuals represented more than half the premium volume in the medical malpractice market. In Minnesota, the Minnesota Medical Insurance Exchange (MMIE) began selling coverage in October of 1980. Today, MMIE is the largest insurer of physicians and surgeons in the state.

D. Claims-made Insurance:

The final significant change resulting from the seventies crisis was the change from an occurrence-based policy form to a claims-made form. In medical malpractice cases, there is often a significant time lag between the date an incident occurs and the date the claim is paid. This long "tail" has contributed to the insurers' difficulties in making accurate actuarial evaluations of malpractice loss experience. The claims-made policy form alleviates some of those difficulties by covering only those claims that are reported while the policy is in effect.

Under the traditional occurrence form, the transfer of risk from the health care provider to the insurance carrier took place when the incident occurred. Under the claims-made form, the transfer of risk takes place only when the claim or incident is reported to the insurance carrier. As a result, the health care provider maintains a risk at any given point in time for incidents that are unreported.

It is estimated that 70-80 percent of the medical malpractice market nationwide is now written on a claims-made basis. In Minnesota, St. Paul Companies shifted to the claims-made form in 1975 and MMIE has written coverage on a claims-made basis since the company's inception in 1980.

E. Malpractice Crisis in the Eighties.

The crisis of the eighties is evidence that the response to the crisis of the seventies did not resolve the problems in the malpractice insurance market. Rate increases in recent years have exceeded those experienced in the 1974-75 crisis and, although virtually everyone agrees a problem exists, there is little agreement on just what or who the "problem" is.

Doctors contend the problem is lawyers and their lawsuit-prone clients, a view shared by many insurers. They believe that many patients have unrealistic expectations of their physicians and the medical profession in general.

The trial lawyers place the blame on medical malpractice insurers and physicians saying they've created a "litigation crisis" as a public relations maneuver. They contend that the problems in the insurance marketplace are caused by the industry's inability and/or unwillingness to avoid the investment and "cash flow" cycles that cause the market disequilibrium.

And in the middle lies the public, who simply do not have independent data available from which to make a conclusion

Not surprisingly, since there is little agreement on the source of the problem, there is less agreement on a solution. Representing many physicians, the American Medical Association (AMA) recently proposed a virtual abandonment of the existing tort liability system. The AMA proposal calls for replacing the current court and jury system with an administrative claims facility. Under the plan, medical malpractice complaints would be reviewed by an expert administrative agency to try to reach a settlement between parties and/or make a determination as to the merits of the case. The agency would also have the power to discipline physicians who demonstrate a pattern of substandard conduct. In addition, the AMA plan would redefine the legal basis for determination of medical liability. Currently, medical liability is based on the standard of care a reasonably prudent physician in a given locality would dispense. Under the AMA proposal, the liability would be based on the standard of care a "prudent and competent practitioner in the same or similar circumstances" would provide, thereby eliminating the locality standard.

The insurance industry asserts that "the only truly viable long range solution lies in comprehensive and substantial tort reform." (Medical Malpractice: A Second Opinion. National Association of Independent Insurers (1986) p.15.) Insurers argue that, when enacted on a comprehensive basis, reforms discussed earlier effectively reduce the costs associated with medical malpractice litigation without restricting the right or ability of individuals to recover just compensation for their injuries. They blame ineffectiveness of reforms in many states on lack of a total commitment to comprehensive reform and implementation of reforms in a piecemeal fashion.

Lawyers and consumer advocates are proponents of increased regulation aimed at stabilizing the insurance market. Their proposals include more state regulatory power over rates; federal anti-trust regulation to eliminate price fixing; the creation of more federal insurance pools including reinsurance pools; mandatory reduction of the number of rating classes used to improve the spread of risk; and use of experience rating rather than class rating alone so that physicians with bad claim records would be penalized.

III. THE STUDY

The impetus for this study was not only the magnitude and far reaching impact of the malpractice crisis but the bewildering array of conflicting statistics and reports on the subject. Rather than reviewing statistical Samples presented by hired consultants representating a particular viewpoint, the Department sought to review every claim filed in the State since 1981. It is believed that this study is the only study in the country where independent examiners reviewed each claim filed in a specific line of insurance.

The review included all medical malpractice claims, open and closed, filed against physicians and surgeons in Minnesota, North Dakota, and South Dakota from 1982 to 1987 at Minnesota Medical Insurance Exchange and St. Paul Fire and Marine Insurance Company.

A. St. Paul Companies:

The St. Paul Companies, Inc. was organized in 1853 in St. Paul, Minnesota under the title of St. Paul Fire & Marine Insurance Company. The medical professional liability is underwritten by a wholly-owned subsidiary of The St. Paul Companies incorporated in 1925 under the title "Mercury Insurance Company." The subsidiary changed its name to St. Paul Fire & Marine Insurance Company when the former St. Paul Fire & Marine changed its status to that of a management company in 1967 and took the title "The St. Paul Companies, Inc." The St. Paul is a large diversified financial company specializing in insurance. In 1988 they acquired a large wholesale and retail insurance broker based in the United Kingdom making St. Paul the seventh largest insurance broker in the world. St. Paul Companies currently writes medical malpractice insurance in 43 states. The Medical Services Division is the largest of the company's underwriting units with the malpractice business accounting for 35 percent of the company's premiums in 1987. The St. Paul Companies has written malpractice insurance since the 1930's and presently writes coverage for doctors, hospitals and other health care specialties. In 1987, they had net malpractice premiums nationwide of $722 million which was about 18 percent of the total market, a market share equal to three times that of their nearest competitor.

B. Minnesota Medical Insurance Exchange:

In Minnesota, the Minnesota Medical Insurance Exchange (MMIE) now insures more than 50 percent of the state's physicians. MMIE began business in October of 1980 in Minneapolis as a reciprocal insurance exchange. It is governed by a board composed of twenty-two physicians appointed by the Minnesota Medical Association. Recently, it reorganized as a stock company to raise more funds and sell more coverage and has subsequently changed its name to Midwest Medical Insurance Company. (At the time this report was compiled, the company was operating as MMIE and is referred to as such throughout the report.) MMIE is managed by Minnesota Medical Management, Inc. and currently has over 3,200 policyholders in three states.

The two companies underwrite their malpractice coverage on similar policy forms (see Appendix A) and at similar policy limits. The policy limits range from $100,000 per occurrence/$300,000 aggregate to $10,000,000 per occurrence/$10,000,000 aggregate. The majority of policies are written either at $1,000,000/$3,000,000 (63.3%) or $2,000,000/$4,000,000 (20.4%) limits.

C. Methodology:

Department examiners reviewed a total of 4,747 medical malpractice files from Minnesota, North Dakota and South Dakota: 2251 files

from MMIE and 2496 files from St. Paul Fire and Marine. The study included all incident reports as well as claim files. Incident reports differ from claim reports in that they are made by physicians and do not necessarily result in a claim. Incident files were included because reserves were usually established for these files. It should be noted, however, that MMIE suspended the practice of setting reserves on incident files in 1985 after determining that these reserves "had not proven helpful in evaluating the total liabilities for MMIE ..." The study did not include claims made against hospitals, clinics or other institutions, nor claims against nurses or other health care providers. A four-page survey form was completed for each file.

The first draft of the questionnaire was developed by the Department's property casualty actuary, general counsel and examination supervisor. The malpractice study conducted by the National Association of Insurance Commissioners (NAIC) in 1976 was used as a reference source and St. Paul Companies also provided information with regard to loss coding procedures. Possible survey questions were considered with an eye toward current issues in the medical malpractice insurance market while taking into account which information examiners could reasonably expect to extract from the files based on their prior experience reviewing claims.

The first draft survey was tested by Department Counsel and the examination supervisor in a review of 40 St. Paul claim files pulled at random by the company. Some modifications were made based on the sample review and a copy of the revised questionnaire was then sent to the St. Paul Companies for comment. The St. Paul expressed concern over the issue of confidentiality with respect to the identity of physicians and claimants and other specifics of individual files, particularly open files where the defense of their insured was at risk. Assurances were given by the Department that the identity of any individuals or specific details relating to an individual file would not be released.

The St. Paul Companies also requested that the wording of question #25 be revised. The original wording read: "Based on the insurer's evaluation of this claim and using your own judgment, do you believe a claim was justified under these circumstances?" St. Paul asked that the judgment of the examiner be eliminated so that the question was based entirely on the judgment of the claims adjustor and/or the defense counsel. The Department made the change. In March, prior to beginning the examination of files at MMIE, the survey form was sent to the company and a similar assurance of confidentiality was given. MMIE did not request any changes be made to the questionnaire.

D. Survey Format:

A copy of the survey form is found on pages eight through eleven of this text. Survey questions one through three record basic identifying information for each file. The loss date and report date recorded in four and five allow for computation of the time lag between the incident giving rise to a claim and the report

of the claim to the insurer, an issue which prompted many insurers to switch to a claims-made policy form.

Question six identifies the specific medical procedure or incident which gave rise to the claim. In addition to being an integral piece of the total malpractice picture, a compilation of the loss cause information was thought to be particularly useful for insurers and health care providers in their loss control efforts. The following question identifying the location where the incident took place was included for similar reasons.

Questions eight and nine record personal characteristics of the claimant. The characteristics of age and sex help answer the question, "Who are the claimants?" This information also enables a comparison of claim frequency and severity for different ages and sexes, information which should be useful to insurers in their reserving practices. For example, the same injury may result in a consistently greater or smaller loss depending on the age and sex of the claimant.

Item ten completes the information about the type of loss along with questions six and seven. Here, the actual injury that resulted from the cause identified in question six is described.

Question 11 was included because of assertions that claimants' lawsuits unjustly include everyone remotely connected to a case. Items 12a-c record information about the physician defendant including specialty and the physician's professional relationship to the claimant. The physician's specialty was included to determine which specialties present the greatest risk and whether the rating classes used by insurers appear to be an accurate reflection of actual risk. Question 12c was an attempt to quantify the physician-patient relationship in order to test the theory that the nature of this relationship can be a contributing factor in decreasing or increasing a physician's exposure in a given situation. Although the claim files may not reveal the finer points of this issue, they often told us whether there had been an ongoing doctor-patient relationship and therefore, presumably increased loyalty or concern for the physician's reputation on the part of the patient.

Questions 13 through 16 are essentially recordkeeping items to decrease the potential for duplicate entries when several defendants were involved in the same claim.

In question 17, the policy limits and deductible were recorded. This information was included in order to identify any correlation between the loss amount and the potential compensation available to a claimant through an insurer. The deductible was noted in order to verify that the loss payment recorded reflected the deductible, if any.

For purposes of data analysis, it was necessary to separate closed from open claims and therefore the status of the file was noted in number 18.

Medical Malpractice
Claim Survey

St. Paul Companies

Initial when completed _____
Date: _____

1. File No. 1. _____

2. Policy No. 2. _____

3. State where loss occurred 3. _____

4. Date of Loss 4. _____

5. Date reported to insurer 5. _____

6. Cause of loss 6. _____

_____ _____

_____

7. Location where injury occurred 7. _____

1. Office
2. Clinic
3. Hospital E.R.
4. Hospital-Surgery
5. Hospital-Labor/Delivery/Nursery
6. Hospital-Patient Care Area
7. Hospital-Outpatient Surgery
8. Hospital-Other
9. Surgi-Center

8. Age of injured person 8. _____

1. 0-30 days
2. 30 days - 2 yrs
3. Over 2 yrs - 12 yrs
4. Over 12 yrs - 18 yrs
5. Over 18 yrs - 35 yrs
6. Over 35 yrs - 55 yrs
7. Over 55 yrs - 70 yrs
8. Over 70 yrs

9. Sex of injured person 9. _____

1. male
2. female

10. Briefly describe principal injury giving a rise to the claim. _____

_____

_____

11. Total number of defendants 11. _____

12. Name of defendant for this file.

_____

a. Profession _____ 12a. _____

b. Specialty _____ 12b. _____

c. Relationship to injured party: 12c. _____

1. Family/personal physician
2. No relationship prior to this injury
3. Other _____

13. Named insured on policy covering above defendant.

_____ _____

a. Named insured is an 1. Institution 13a. _____
2. Individual
3. Group

14. List any other defendants in this case covered by the same policy given in #11. 14. _____

Name	Claim File # (if known)
_____	_____
_____	_____
_____	_____

15. List any other defendants also covered by this insurer but under a different policy. 15. _____

_____

_____

16. List other defendants not covered by this insurer. 16. _____

_____

_____

17. Policy limits.

a. _____ occurrence 17a. _____

b. _____ aggregate 17b. _____

18. Status of claim. 18. _____

1. open
2. closed on___/___/___

19. If claim is open, indicate:

a. beginning loss reserve 19a. _____
b. current loss reserve 19b. _____
c. current LAE reserve 19c. _____
d. settlement demand 19d. _____

ANSWER QUESTIONS 20 - 24 ONLY IF CLAIM IS CLOSED.

20. If claim is closed, indicate:

a. beginning loss reserve 20a. _____
b. ending loss reserve 20b. _____

21. Method of disposition 21. _____

1. settled
2. tried
3. arbitration

22. Indicate amount of settlement or verdict broken down as follows:

a. medical expenses 22a. _____
b. future medical expenses 22b. _____
c. pain and suffering 22c. _____
d. lost wages incurred 22d. _____
e. lost wages anticipated 22e. _____
f. punitive damages 22f. _____
g. other 22g. _____
h. total 22h. _____

23. Indicate amount paid to claimant:

a. total amount paid to claimant 23a. _____
b. by this insurer 23b. _____
c. deductible paid by insured over limits 23c. _____
d. amount paid by insurer over limits of policy 23d. _____
e. amount paid by excess coverage insurer 23e. _____
f. amount paid by other defendants/ contributors 23f. _____

24. Amount of allocated loss adjustment expenses:

a.	total LAE	24a. _____
b.	claim investigation	24b. _____
c.	court costs	24c. _____
d.	internal defense counsel	24d. _____
e.	external defense counsel	24e. _____
f.	other	24f. _____

25. Based on the adjuster/defense counsel's evaluation of this claim, does it appear a claim was justified under the circumstances of this injury? 25. _____

1. definitely
2. probably
3. doubtful
4. definitely not
5. uncertain

26. Additional Comments/Observations:

_____

_____

_____

_____

Because different information could be obtained depending on the status of the file, a separate set of questions was developed for open and closed files. Obviously, if a file remains open, information regarding the disposition of the claim and the loss payment are not available. Therefore, in question 19 we recorded loss and loss expense reserves and the settlement demand if one had been made. The reserve amounts are necessary to the calculation of loss ratios. Reserving practices have consistently been an issue in the malpractice debate as lawyers and consumer groups have blamed overly conservative reserves for what they claim are inflated loss ratios published by insurers. In order to address the reserving issue, we recorded both the beginning loss reserve (the reserve set when the file was opened) and the ending reserve (the last reserve recorded prior to the closing of the file.) This was done to trace the progress of the reserve (in a limited way) and also to compare the ending reserves to the actual loss payment to gauge the accuracy of reserving.

Question 21 identified the method of disposition of a closed claim. Much of the media coverage of malpractice issues focuses public attention on jury verdicts and tried cases. Therefore, by separating the claims according to method of disposition, the various expense levels and final outcomes of tried claims as opposed to settled claims could be compared, for example.

Question 22 was directed toward some of the issues in the tort reform controversy. Insurers have pushed for caps on noneconomic damages as part of the solution to the rising costs of malpractice insurance. In order to determine the effect of noneconomic damages on overall loss experience, in question #22 the settlement or verdict was broken down into its various components.

Claimants may receive compensation through more than one source. Question 23 identified the various sources of compensation so that an accurate reading of the losses actually paid by the insurer as opposed to the total compensation awarded a victim could be obtained.

Insurers have pointed to the rising cost of claims management, regardless of whether any loss payment is ever made, as another factor in the rising cost of insurance. Question 24 broke down the allocated loss adjustment expense (LAE) costs according to investigation, court, and legal expenses.

Another argument evoked by insurers when explaining the rising cost of insurance is the large number of frivolous claims and their impact on insurance costs. Question 25 was included to determine the volume of frivolous claims and their cost to insurers.

Finally, space was included for additional comments and observations. Examiners used this section to record observations such as "new file - little information available" or other pieces of information that were not captured in the more quantitative survey questions but which could shed light on the claim.

E. Field Review:

The examiners began their review at St. Paul's Upper Midwest Service Center in Bloomington, Minnesota on January 19, 1988. The number of examiners reviewing files at any one time ranged from one to four. However, three examiners worked for seven weeks of the nine week examination at St. Paul. Department staff were provided a conference room in which to work and a photocopy machine was available for their use. Company employees were cooperative and available to answer examiners' questions. Over 250 of the files given to the examiners were incorrectly identified by the company as being within the survey's parameters. These files were rejected for a number of reasons including files where: The policyholder was not in one of the survey states (for example, frequently, Montana files were found); the claim was made against a health care professional other than a physician; or the claim was made against a clinic or hospital - although examiners did include claims against physicians where the named insured on the policy was a hospital or clinic.

Examiners encountered some difficulties in extracting information from St. Paul's files. Documents within each file were kept in approximate chronological order, however, examiners found a significant number of duplicate documents such as memos, depositions and medical records, which increased their time spent reviewing. In addition, medical records which were detailed and voluminous were often not separated from other file documents making it more difficult to sift through files for the survey information.

Examiners also had difficulty determining the date when the insurer was notified of the claim because frequently several different dates were listed as the report date or notice date in various parts of the file. Since it is the notice date that determines in which year's loss experience a claim is placed, determining the date accurately was an important concern. When examiners raised this issue with the service center staff, they were directed to use the report date listed on the computer printout label found on the cover of each file.

The initial examination at St. Paul was completed on March 23, 1988. Following the completion of the file review at St. Paul, field examiners and the examination supervisor developed data codes for survey questions where an appropriate code system could not be identified prior to the review. The St. Paul data was then entered on a Department computer using a DBASE program. Data entry and coding were performed by the same examiners who reviewed the files for maximum accuracy and consistency. Entry of St. Paul data was completed in approximately two and one-half weeks. Examiners returned to review some additional files retrieved by St. Paul on April 15 for three days.

On April 20, examiners began to review files at MMIE. The same three examiners who reviewed most of St. Paul's files also reviewed MMIE's. Department staff were accomodated in a conference room and had a photocopy machine at their disposal. As with St. Paul,

MMIE's staff was cooperative and available to answer questions. MMIE's files were organized chronologically, however, they did separate the medical records from the other documents within each file. MMIE's files contained fewer duplicate documents than St. Paul's which also decreased examiners' review time. After the first day at MMIE, examiners revised the order of the survey questions to accommodate more efficiently the MMIE file arrangement. The review at MMIE was completed on July 8, 1988 and data was again entered using the same format and procedures as were used for the St. Paul data.

F. Data Reconciliation

Following completion of the data entry process, a variety of data reports were run and staff began checking for data entry errors and organizing data in an appropriate format for use in this report. In late August, examiners noticed a significant discrepancy between the number of claim files listed on loss experience data sheets supplied by St. Paul Companies prior to the file review and the number of files actually reviewed. The Department's first inquiries regarding the discrepancy were met with assurances from St. Paul that the Department had in fact reviewed all their claims against physicians and surgeons. However, after the magnitude of the discrepancy, over 400 files were verified, St. Paul officials informed the Department they believed some files had inadvertently been omitted from the review. Company officials explained that the problem resulted from a communication breakdown between their actuarial department and their claims department as to the "definition of a physician and surgeon claim." For the next four weeks, St. Paul officials sought to determine which files the Department had reviewed and which it had not. During this period, the Department supplied a computer run list of file numbers that had been reviewed. St. Paul then used the list to cross check against their own. Both the Department's list and St. Paul's list were organized by report date. Apparently due to the conflicting information in the files, the two lists did not coincide with regard to report year thereby making files more difficult to cross reference. Consequently, if St. Paul located a file the Department had reviewed but had listed it in a different report year, the Department changed its data base to reflect the date in St. Paul's data base. A total of 197 report dates were changed.

Examiners returned to St. Paul's Upper Midwest Service Center on October 5, 1988 to review the files St. Paul had identified as the remainder of the survey group. Over the course of the next week, examiners reviewed 249 additional St. Paul files. The remaining discrepancy between the original St. Paul figures and the number of files reviewed was explained by the fact that when more than one claimant is involved in a lawsuit, the company counts one claim for each claimant, even when there is only one claim file. In addition, the service center staff was unable to locate the hard files for 50 claims listed in the actuarial division's data base. They did provide the Department with a computer run summary of 45 of the missing files. The Department accepted the 45 claims listed on the computer reports for both the claims center

and the actuarial division even though no claim file was found. This data is included in the study. With regard to the five claims found on the actuarial computer but not the claims center computer, the Department stated it would include such files if they could be found. No such files were found.

G. Company Verification of Data

Following St. Paul Companies' review of this report, they noted that the report differed from their own data in the areas of loss payments and loss expenses on closed files. The Department agreed to review again all individual files where a discrepancy was found. Accordingly, St. Paul Companies and Department personnel reviewed all files where there was a discrepancy of over $100. In files with lesser discrepancies, St. Paul's figures were accepted. Corrections were agreed on between both parties and were then made in the Department's database. These corrections did not result in any notable increase or decrease in the aggregate figures. Approximately the same number and amount of upward and downward dollar figure adjustments resulted from the review.

IV. FINDINGS

A. General

Seventy-eight percent (3689) of the claim files reviewed were closed and twenty-two percent (1058) were open. The following section also refers to a subgroup of closed files identified as "loss files" which includes only those closed claims where a loss payment was made by the insurer. Twenty-seven percent (982) of the closed files were loss files. The remaining seventy-three percent involved no compensation to the claimant by the insurer.

It should be noted that the data in this report is organized according to the year each claim was reported. Accordingly, unless otherwise stated, all references in text and the tables to "year" is a reference to the report (or notice) year of the claim.

The data in the report does not take reinsurance into account in calculating losses. Some of the larger losses in the study were paid in part by reinsurance therefore reducing the amount actually paid by the primary insurer. However, reinsurance also is an expense for insurers and is a factor in setting the target loss ratios discussed below. Reinsurance is a greater relative expense for MMIE than St. Paul Companies because of the company's smaller size and the fact that MMIE has been in business for a shorter length of time.

The loss payments ranged from $0 to $1,296,090. The average loss payment for all closed claims was $14,542 and the median was zero. The average loss payment on loss files only was $54,629 and the median was $15,000.

There were three files (0.1 percent of closed claims) where a company paid one million dollars or more, 15 files (0.4% of closed claims

where the payment was equal to or greater than $500,000, and 145 claim files (four percent of closed claims) where the loss payment was equal to or greater than $100,000. One of the three payments that met or exceeded $1.0 million was the result of a jury verdict, the other two resulted from negotiated settlements.

B. Loss Ratios

A loss ratio is derived by dividing the sum of the loss payments, loss adjustment expense (LAE), loss reserve, and allocated LAE reserve by earned premium. Allocated LAE represents expenses that insurance companies pay to outside entities such as expert witnesses and attorneys during the course of investigating and litigating a claim. Both MMIE and St. Paul Companies have a targeted loss ratio of 82-85 percent.

It was the Department's intention not to include reporting endorsement premium and losses in this report. Reporting endorsement coverage, commonly known as "tail" coverage, essentially converts a claims made policy to an occurrence policy.

After the report was complete, however, MMIE advised the Department that reporting endorsement premium and loss files had been included in the review at the company. Because reporting endorsements are written on an occurrence basis, MMIE reserves for claims "incurred but not reported" (IBNR reserves) were added to the loss reserve data in the loss ratio calculation. This resulted in an upward adjustment of overall loss ratio by .5 percent.

The overall loss ratio (as determined by the value of the claims on the day the Department reviewed the files) for the six-year period of the study was 71.8 percent. That is, the 4,747 claim files had losses and reserves totalling $182,742,647 which is divided by earned premiums of $254,597,909. Table 1 below gives the loss ratio and its various components for each year of the study. The loss experience for each of the three states individually is found in Appendix B.

It should be noted that reserves are, by definition, estimates. In addition, medical malpractice is a line of insurance that, by its very nature, requires long periods for claim settlement. There is a good probability that claims from the most recent report years, especially 1986 and 1987, will see a number of reserve changes before they are finally paid. As a result, the 1986 and 1987 loss ratios should be viewed as less stable than earlier years. The degree to which reserves are accurate obviously affects fluctuations in loss ratios over time. Reserving accuracy is discussed in section D below.

TABLE 1:
PHYSICIAN MALPRACTICE LOSS EXPERIENCE
COMBINED STATES BY YEAR

REPORT YEAR	QUANTITY CLAIMS	EARNED PREMIUM	PAID LOSS	PAID LOSS EXPENSE	OUTSTANDING LOSS RESERVE	OUTSTANDING LOSS EXP.	TOTAL LOSSES and RESERVES	LOSS RATIO
1982	721	$23,369,849	$16,034,369	$3,833,712	$2,555,000	$ 290,005	$22,713,086	97.2%
1983	776	26,940,428	7,729,884	2,513,698	3,040,501	548,524	13,839,607	51.3
1984	768	32,489,891	12,009,664	3,546,127	8,780,000	1,431,037	25,816,828	79.3
1985	937	43,451,439	10,648,054	3,877,240	19,674,353	2,706,981	37,036,628	85.4
1986	758	57,001,803	5,230,846	2,071,814	27,119,856	5,637,437	40,409,953	70.9
1987	787	71,344,499	1,993,071	761,053	32,655,891	6,916,530	42,926,545	60.2
TOTALS	4,747	$254,597,909	$53,645,888	$16,603,644	$93,825,601	$17,530,514	$182,742,647	71.8%

C. Claim Frequency and Severity

Claim frequency and severity are indicators commonly used in analyzing loss data. Claim frequency is the number of claims made per policyholder. Claim severity is the average size of a claim measured in dollars paid and reserved. Frequency and average severity are important to examine because increases in both have been blamed for the shortage in insurance coverage. If a "litigation explosion" has occurred, it should be reflected in the frequency and severity numbers.

It would appear, however, that the data does not substantiate the litigation explosion assertions. Claim frequency has not changed measurably in the last six years. The 1987 frequency rate is actually less than the 1983 rate. Table 2 illustrates this trend.

TABLE 2: CLAIM FREQUENCY 1982 - 1987

YEAR	NUMBER OF INSUREDS	QUANTITY CLAIMS	CLAIMS PER 100 INSUREDS
1982	6,912	721	10.4
1983	6,605	776	11.7
1984	6,599	768	11.6
1985	6,942	937	13.5
1986	7,072	758	10.7
1987	6,836	787	11.5
TOTAL/AVG.	40,966	4,747	11.6

Claims severity trends also do not evidence a litigation explosion. Both averages and medians may indicate trends in claim severity. The median loss payment for each year was $0. Table 3A compares average loss payments on all closed files and on loss files only. Average payments actually appeared to be decreasing over the period of the study.

It should be noted that the 1986 and 1987 averages do not have substantial credibility due to the large percentage of claims still open.

TABLE 3A: CLAIM SEVERITY 1982 - 1987

YEAR	NUMBER OF CLOSED CLAIMS	PERCENT OF TOTAL CLAIMS	AVERAGE LOSS PAYMENT	PERCENT OF CLOSED CLAIMS WITH LOSSES	NUMBER OF OPEN CLAIMS	AVERAGE OPEN RESERVES	AVERAGE TOTAL
1982	700	97.1%	$22,906	31.0%	21	$121,667	$25,783
1983	741	95.5	10,432	30.6	35	86,871	13,880
1984	685	89.2	17,532	27.6	83	105,783	27,070
1985	783	83.6	13,599	23.6	154	127,756	32,361
1986	516	68.1	10,137	21.3	242	112,066	42,679
1987	264	33.5	7,550	20.5	523	62,440	44,027
TOTAL	3,689	77.7%	$14,542	26.6%	1,058	$ 88,682	$31,066

The "average total" column includes both paid losses and unpaid reserves. Although this column would seem to indicate an upward trend in severity, the discussion below suggests that inflated reserves distort these figures. The more claims that are open, the greater the upward distortion.

After reviewing this report, St. Paul Companies and MMIE objected to the Department's presentation of claim severity in Table 3A arguing that severity must be measured by comparing claims at the same point in their development. Accordingly, Table 3B compares average loss payments for closed claims at the same year of development. For example, a claim reported in 1982 and closed in 1982 would be directly comparable to a claim reported in 1984 and closed in 1984. Both were closed in "year 1" of their development. If claims are becoming more severe, an upward trend would be reflected in these comparisons.

TABLE 3B: CLAIM SEVERITY FOR POLICY YEARS 1982-1987
MEASURED AT EQUAL POINTS OF LOSS DEVELOPMENT

NOTICE YEAR	AVERAGE CLAIMS CLOSED YEAR 1	LOSS CLAIMS CLOSED YEAR 2	PAYMENTS CLAIMS CLOSED YEAR 3	CLAIMS CLOSED YEAR 4	CLAIMS CLOSED YEAR 5
1982	$5,391	$11,567	$21,857	$49,668	$41,963
1983	1,801	4,885	13,665	17,602	36,649
1984	6,690	14,303	10,592	52,712	
1985	8,309	6,987	25,697		
1986	3,040	7,504			
1987	4,604				
TOTAL NUMBER OF CLOSED CLAIMS (by development year)	726	1,527	724	263	109

If average loss payments were becoming increasingly severe, each column of figures in Table 3B should show an upward trend. However,

Table 3B clearly indicates there has been no upward trend in claim severity based on a comparison of loss payments at equal points in loss development.

Attached as Appendix D is a graph of the figures set forth in Table 3B.

D. Accuracy of Loss Reserves

Table 4 compares the reserve established when the file was opened (beginning reserve), the last reserve recorded before the file was closed (ending reserve) and the average loss payment, for all closed files. Although the beginning reserve has, on average, been less than the eventual loss payment, the beginning reserve is significantly closer to the average loss than is the ending reserve. The average loss payment for the six year period is 117 percent of the average beginning reserve but only 36 percent of the average ending reserve. A random sample of 150 claims indicated that the ending reserve is set an average of three months after the beginning reserve is first set. Therefore, at any given time, most of the open reserves are "ending reserves" rather than "beginning reserves."

TABLE 4: LOSS RESERVE ACCURACY CLOSED FILES

YEAR	I AVERAGE BEGINNING RESERVE	II AVERAGE ENDING RESERVE	III AVERAGE LOSS PAYMENT	IV AVERAGE DOLLAR DIFFERENCE (II - III)	V LOSS PAYMENT AS A PERCENT OF THE FINAL RESERVE (III ÷ II)
1982	$16,433	$40,532	$22,906	$17,626	56.5%
1983	10,752	34,922	10,432	24,490	29.9
1984	12,136	47,519	17,532	29,987	36.9
1985	12,418	46,165	13,599	32,566	29.5
1986	10,694	41,755	10,137	31,618	24.3
1987	10,368	23,226	7,55[illegible]	15,676	32.5
	$12,405	$40,831	$14,542	$26,289	35.6%

It is apparent from the data that the insurers have consistently and significantly over-reserved. Ending reserves have been three times higher than actual loss payments for the last five years. A further comparison of loss payments and open reserves is found in Appendix C.

The insurers have accurately pointed out that over reserving does not necessarily lead to artificially high rates if actuaries reduce the reserve levels appropriately during the rate making process. However, rate filings published by these insurers indicate their actuaries have not compensated adequately for the companies' conservative reserving when developing rates. Both companies apply a loss and loss expense reserve development factor in their ratemaking formula. This factor averaged for the period of the study was .69

for MMIE and .79 for St. Paul Companies. Thus, although MMIE is closer, both companies fall short of an accurate development factor.

E. Allocated Loss Adjustment Expense (LAE)

The allocated LAE for closed claims ranged from 0 to $177,628. The average allocated LAE for all closed claims was $3,244 while the median was $144. For loss files only, the average allocated LAE was $6,573 while the median was $989.

There were seven claims (0.2% of closed claims) where allocated LAE reached or exceeded $100,000.00, 96 claims (2.6% of closed claims) where it was equal or greater than $25,000, and 300 claims (8.1% of closed claims) where the allocated LAE was greater than or equal to $10,000. Table 5A shows the average allocated LAE for closed claims, the average reserve for open claims and the combined average for open and closed files. Insurance companies spent an average of $330 on files where the claim was not pursued by the claimant. A typical example of such a claim is where the physician filed an incident report and no claim was ever filed by the patient.

Insurers argue that the rising costs of defending claims is one cause of the malpractice crisis. Table 5A indicates that the highest defense cost year was 1982, and that costs have actually decreased since that time. Once again, the percentage of claims still open in 1986 and 1987 make a direct comparison with other years less credible. Nevertheless, the figures do not seem to reverse the overall trend of decreasing costs.

TABLE 5A: AVERAGE ALLOCATED LAE

YEAR	NUMBER OF CLAIMS	AVERAGE INCURRED LAE (CLOSED CLAIMS)	NUMBER OF OPEN CLAIMS	AVERAGE LAE RESERVE (OPEN CLAIMS)	AVERAGE LAE INCURRED & RESERVED (CLOSED & OPEN FILES)
1982	721	$5,090	21	$13,810	$5,719
1983	776	2,995	35	16,133	3,967
1984	768	3,781	83	17,241	6,481
1985	937	3,072	154	17,578	7,027
1986	758	1,738	242	23,295	10,170
1987	787	1,111	523	13,225	9,756
TOTAL	4,747	$3,244	1,058	$16,585	$7,194

The same argument the insurers made regarding Table 3A and claim severity trends (see p. 18) could also be made with regard to the LAE severity trends reflected in Table 5A. Accordingly, Table 5B is a comparison of average allocated LAE according to the loss development year.

TABLE 5B: AVERAGE ALLOCATED LAE
BY EQUIVALENT DEVELOPMENT YEAR

POLICY YEAR	CLAIMS CLOSED YEAR 1	CLAIMS CLOSED YEAR 2	CLAIMS CLOSED YEAR 3	CLAIMS CLOSED YEAR 4	CLAIMS CLOSED YEAR 5
1982	$ 522	$1,438	$4,586	$8,902	$13,879
1983	316	625	3,249	6,604	13,934
1984	185	1,350	2,670	17,065	
1985	479	1,200	6,300		
1986	382	1,300			
1987	562				
TOTAL NUMBER OF CLAIMS CLOSED	726	1,527	724	263	109

Once again, if loss adjustment expenses were increasing, each column in Table 5B should show an upward trend. However, this table clearly indicates no discernable upward trend in loss adjustment expenses when comparing claims at equal points in their development.

F. Disposition of Closed Claims

The claims were resolved through numerous methods which are categorized in Table 6. Files where there was no loss payment account for 73.4 percent of all closed files. Over one-third of the files were closed due to a lack of activity or pursuit by the claimants.

TABLE 6: DISPOSITION OF CLOSED FILES

DISPOSITION	TOTAL FILES	PERCENT OF TOTAL	AVERAGE LOSS PAYMENT	AVERAGE LAE	AVERAGE TOTAL COST
No Activity/Not pursued	1,325	35.9%	N/A	$ 330	$ 330
Settled	1,073	29.1	$45,364	5,449	50,813
Dismissed	457	12.4	N/A	2,604	2,604
Dismissed with Prejudice	260	7.1	N/A	3,423	3,423
Statute of Limitations Expired	240	6.5	N/A	478	478
Tried	110	3.0	40,042	27,907	67,949
Summary Judgement	82	2.2	N/A	3,112	3,112
Claim Denied	59	1.6	N/A	306	306
Unknown	52	1.4	10,527	1,780	12,307
Conciliation Court	26	0.7	78	1,094	1,172
Arbitration	5	0.1	3,250	5,001	8,251
TOTAL	3,689	100.0%	$14,542	$ 3,244	$17,786

Three percent (110) of the closed claims were decided by a jury. The defense prevailed in 81 percent (90 of 110) of the tried cases. Claims that were tried cost the insurance companies over five times as much, on average, in allocated LAE than settled claims. However,

the average loss payment was considerably less on the tried claims than those that were settled. Thus, the cost for litigated cases exceeded the cost of negotiated cases by 33.7 percent. There is no evidence that the percentage of claims being tried is increasing. For the years 1982-85 where most files have been closed, the percentage of cases tried has remained remarkably constant: 1982, 6.7 percent; 1983, 3.2 percent; 1984, 2.9 percent; 1985, 2.2 percent.

TABLE 7: COMPARISON OF COSTS
SETTLED VERSUS TRIED CLAIMS

	NUMBER OF CLAIMS	AVERAGE LOSS PAYMENT	AVERAGE LAE	TOTAL COST
CLOSED SETTLED CLAIMS	1073	$45,364	$ 5,449	$50,813
CLOSED TRIED CLAIMS	110	$40,042	$27,907	$67,949

G. Non-economic Damages

Non-economic damages have been a central issue in the malpractice debate. Insurers have asserted, "The huge amounts awarded (by juries) for punitive damages, pain and suffering, and other non-economic loss provide a windfall for the plaintiff while resulting in substantial costs to all other patients in the aggregate." (Medical Malpractice: A Second Opinion. National Association of Independent Insurers (1986) p.10) There were no punitive damages awarded in any of the 110 cases that were tried in the three survey states during the last six years. Further, both companies exclude punitive damages under the terms of their policy. There also were no pain and suffering awards specified in any of the jury verdicts in the study. It should also be noted that the entire issue of non-economic damages is minimized by the fact that there were only 20 cases where any compensation was awarded a plaintiff by a jury verdict due to physician malpractice. Thus, there is no data upon which the insurer can argue that damages for non-economic loss have increased.

H. Physician Specialty

The physicians who were the object of claims have been classified by specialty using the thirty categories listed in Table 8. The table shows the relative market presence of each specialty as a percentage of the total number of insureds and the corresponding percent of total claims and dollar losses for the six years of the study.

TABLE 8: EXPERIENCE COMPARISON
BY PHYSICIAN SPECIALTY

SPECIALTY	PERCENT OF INSUREDS	PERCENT OF CLAIMS	PERCENT OF DOLLAR LOSSES
General/Family Practice	35.6%	22.3%	35.3
Internal Medicine	11.1	6.6	4.6
Pediatrician	5.2	2.4	1.4

Table 8 cont.

SPECIALTY	PERCENT OF INSUREDS	PERCENT OF CLAIMS	PERCENT OF DOLLAR LOSSES
General Surgeon	5.1	10.3	16.6
Obstetrician/Gynecologist	4.9	10.1	8.2
Anesthesiologist	4.0	4.0	1.6
Orthopedic Surgeon	3.8	7.6	7.0
Emergency Medicine	3.5	1.5	1.0
Ophthalmologist	3.4	2.2	1.1
Pathologist	3.0	0.7	0.7
Radiologist	2.9	3.5	2.7
Psychiatrist	2.7	1.6	0.7
Unknown/Other	2.6	15.5	9.5
Neurologist	2.3	2.9	1.6
Urologist	1.7	1.8	1.1
Cardiologist	1.4	1.4	1.6
Dermatologist	1.1	0.5	1.2
Ear/Nose/Throat	1.1	1.5	0.3
Plastic Surgeon	1.0	1.1	0.6
Allergist	0.6	0.3	0.0
Oncologist	0.5	0.4	0.8
Thoracic	0.5	0.6	0.3
Gastroenterologist	0.4	0.3	0.1
Occupational Medicine	0.4	0.2	0.3
Endocrinologist	0.3	0.1	0.0
Pulmonary Specialist	0.3	0.1	0.3
Colon & Rectal	0.2	0.3	1.5
Geriatrics	0.2	0.0	0.0
Rheumotologist	0.2	0.1	0.0
Neonatalogist	0.1	0.1	0.0

General surgeons, orthopedic surgeons, and obstetricians/gynecologists have a claim rate that is approximately double their presence in the marketplace. General/family practice physicians, as well as internal medicine specialists, pathologists, ophthalmologists, psychiatrists, dermatologists, allergists, emergency medicine specialties, and pediatricians all have significantly fewer claims than one would expect based on their relative numbers.

Tables 9-11 below show the average loss payment and average allocated LAE for specialties where there was a minimum of ten closed claims. For comparison purposes, the overall average loss payment for all closed claims was $14,542, and the average allocated LAE was $3,244.

TABLE 9: SPECIALTIES WITH HIGHER THAN AVERAGE PAYMENTS

SPECIALTY	CLOSED CLAIMS	AVERAGE LOSS PAYMENT	AVERAGE LAE
Dermatologist	20	$32,279	$3,273
Oncologist	15	28,049	3,429
General/Family Practice	835	22,706	4,388
General Surgeon	401	22,049	3,580

TABLE 10: SPECIALTIES WITH
NEAR AVERAGE PAYMENTS

SPECIALTY	CLOSED CLAIMS	AVERAGE LOSS PAYMENT	AVERAGE LAE
Cardiologist	54	$15,399	$4,892
Pathologist	28	14,185	4,669
Orthopedic Surgeon	283	13,208	2,866
Radiologist	123	11,883	1,981
Ob/Gyn	386	11,364	3,105

TABLE 11: SPECIALTIES WITH
BELOW AVERAGE PAYMENTS

SPECIALTY	CLOSED CLAIMS	AVERAGE LOSS PAYMENT	AVERAGE LAE
Emergency Physician	52	$10,081	$1,682
Internal Medicine	244	10,031	2,253
Unknown	520	9,329	3,023
Urologist	64	9,392	3,604
Neurologist	94	9,124	2,604
Pediatrician	88	8,580	1,495
Plastic Surgeon	41	7,405	2,741
Psychiatrist	53	7,383	4,509
Opthalmologist	84	6,966	3,022
Thoracic	27	6,791	2,890
Anesthesiologist	161	5,473	2,043
Ear/Nose/Throat	45	3,275	2,359

The obstetrician/gynecology specialty has been a primary focus in the malpractice debate. The tables indicate that while their frequency rate is higher than average, the average loss payments for obstetricians is $3,000 below the average for all physicians. General surgeons are an example of a specialty with higher than average frequency and severity while emergency physicians are below average in both categories.

It should be noted that, when broken down by specialty, the size of the sample is not large enough to draw any definite conclusions relative to the experience of any one specialty.

I. Location of Injury Occurrence

The location where the injuries occurred were separated into seven areas. The distribution of claims by location are shown in the table below.

TABLE 12: LOCATION OF INJURY OCCURRENCE

LOCATION	PERCENT TOTAL	AVERAGE PAYMENT CLOSED FILES	AVERAGE PAYMENT LOSS FILES
Surgery	34.3%	$13,000	$45,571
Clinic	23.1	12,173	45,327
Patient Care Area	10.5	14,326	58,876
Labor/Delivery/Nurs.	9.4	32,505	117,654
Emergency Room	9.0	20,334	67,985
Office	7.6	9,324	36,674
Hospital-Other	4.6	4,601	31,826
Other/Unknown	1.5	3,543	29,357
TOTAL/AVERAGE	100.0%	$14,542	$54,629

The most expensive injuries are those that occur during labor and delivery. The largest percentage of claims results from events occurring in the operating room, accounting for over one-third of all claims made.

J. Cause of Loss

The causes of the injuries resulting in claims were identified by using the 107 different categories developed and used by St. Paul Companies (see Appendix D). Eighteen of these causes contributed more than one percent of the total claims (open and closed) and they are listed in Table 13 below. The table also gives the average loss payment for closed claims and average payment on loss files only.

TABLE 13: COMPARISON OF LOSS CAUSES

CAUSE OF LOSS	QUANTITY OF CLAIMS	PERCENT OF ALL CLAIMS	AVERAGE LOSS PAYMENT	AVERAGE PAYMENT LOSS FILES
Post Operative Complications	774	16.3%	$11,382	$44,859
Other	657	13.8	5,932	32,406
Birth Related Problems	394	8.3	31,891	142,514
Failure to Diagnose Cancer	250	5.3	21,483	89,202
Surgery, Inadvertant Act	234	4.9	15,802	49,347
Failure to Diagnose FX/Dislocation	198	4.2	4,933	20,381
Improper Treatment FX/Dislocation	172	3.6	11,391	42,565
Drug, Side Effect	121	2.5	10,007	41,394
Failure to Diagnose Infection	112	2.4	55,597	166,790
Surgery, Inappropriate Procedure	105	2.2	15,972	53,025
Pregnancy Related Problems	103	2.2	21,923	68,204
Failure to Diagnose Heart Attack	84	1.8	31,949	118,669
Lack of Supervision/Control	74	1.6	3,462	15,981
Incorrect Drug	74	1.6	28,689	67,419
Unnecessary Surgery	67	1.4	5,779	10,422
Post Operative, Death	64	1.3	14,250	51,061
Lack of Informed Consent	60	1.3	13,628	43,439
Surgery, Sponge Left	52	1.1	4,203	6,693
TOTAL/AVERAGE	3,595	75.7%	$14,542	$54,629

The highest average payments were made on claims arising out of birth related injuries and failure to diagnose an infection. These were the only two types of causes where the average payment on loss files only exceeded $100,000. The category "other" is not "unknown", but rather is a cause that is not included on our list. The relatively large size of this category is due to the many claims that result from unusual and unique events which are difficult to categorize.

Table 14 illustrates a more general breakdown of the loss causes through a combination of related types of injuries. These ten categories account for nearly eighty percent of all claims.

TABLE 14: LOSS CAUSE COMPOSITE

CAUSE OF LOSS	PERCENT OF ALL FILES
Surgical Related Problems	29.5%
Other	13.8
Pregnancy/Birth Related	10.7
Fracture/Dislocation Related	7.8
Failure to Diagnose Cancer	5.3
Drug Related	5.3
Failure to Diagnose Infections	2.4
Failure to Diagnose Heart Attack	1.8
Lack of Supervision/Control	1.6
Lack of Informed Consent	1.3
TOTAL	79.3%

K. Characterization of Claimants

The ages of the claimants were grouped according to the breakdowns listed in Table 15. The average loss payment was the highest for the youngest of all claimants. It then declined to a low in the teen years and began rising during the wage earning years reaching a second (lower) crest during the peak wage earning years of 35-55. It then dropped continuously as age increased.

TABLE 15: COMPARISON OF LOSSES
BY AGE OF CLAIMANT

	PERCENT ALL CLAIMS	AVERAGE PAYMENT CLOSED FILES	AVERAGE PAYMENT LOSS FILES
Birth - 30 Days	5.8%	$35,273	$133,175
Over 30 Days - 2 Years	3.7	20,188	80,750
Over 2 Years - 12 Years	3.2	12,405	51,528
Over 12 Years - 18 Years	4.0	8,319	26,849
Over 18 Years - 35 Years	30.6	13,505	48,591
Over 35 Years - 55 Years	22.1	19,180	68,283
Over 55 Years - 70 Years	15.1	13,361	51,537
Over 70 Years	6.7	8,385	31,321
Unknown	8.9	4,991	24,125
TOTAL/AVERAGE	100.0%	$14,542	$54,629

Female claimants accounted for 56.3 percent of all the claimants while 42.7 percent of the claimants were male. In 1.0 percent of the files there was too little information to determine the sex of the claimant. The average loss payment for males was $18,107 compared with $12,119 for females, making the average loss payment for males nearly 55 percent more than the average for females.

L. Relationship of Claimant and Physician

In reviewing files, the examiners sought to determine whether the claim was the result of a visit to the claimant's regular physician or the result of a first or second time visit to a physician not seen regularly. In the case of specialists, they determined whether or not the claimant had been seeing this specialist for a problem over a period of time. An example would be a woman who had a family practice physician but who saw an obstetrician during her pregnancies. Both physicians, in this case, would be considered her regular doctor.

Claims made against physicians who were believed to have seen the claimant no more than a couple of times accounted for 62.8 percent of all claims compared with 26.7 percent which were filed against the claimants' regular physicians. In 10.5 percent of the claims this relationship could not be determined. The average loss payment made on behalf of a claimant's regular physician was $18,122 while an average of $13,337 was paid on behalf of physicians who were not seen by the claimant on a regular basis.

While this data may indicate that patients are less likely to file a claim against a physician with whom they have had an on-going relationship, it may also be an indication of the increased risk associated with the work of specialists who frequently would not be categorized as a "regular physician."

M. Frivolous Claims

As stated earlier, question #25 of the survey form was included to determine the volume of frivolous claims. It should be noted that the results of the question as phrased reflect the companies' evaluation of the physician's liability rather than the examiner's evaluation. The files indicate that 8.6 percent of all claims reported definitely involve liability and 16.8 percent probably do, according to the insurers. The files also indicate that liability was doubtful in 28.3 percent of all claims and that physicians liability was virtually ruled out by the company in 10.5 percent of the cases. Liability was uncertain in 34.4 percent of the files reviewed.

If the frivolous claims are defined as those identified by the company as cases of definite absence of liability on the part of the physician, then frivolous claims cost an average total of $112,940 per company annually in loss and loss adjustment expenses. If the definition of a frivolous claim is broadened to include those claims the companies identified as doubtful liability cases, the annual cost per company increases to $615,532.

Comparing these frivolous claim costs to earned premium, the data indicates that such claims cost insurers between .5 percent and 3 percent of earned premium each year, depending on whether the narrower or wider definition of a "frivolous claim" is used. The assertion that frivolous claims are to blame for rapidly rising insurance rates or that an explosion of frivolous suits has occurred is not substantiated by the data.

The data does not indicate any increase in frivolous claims over the last six years. Table 16 shows the percentage of all claims where liability was judged improbable or ruled out by the company.

TABLE 16: FRIVOLOUS CLAIM TRENDS

REPORT YEAR	TOTAL CLAIMS REPORTED	"NO LIABILITY" CLAIMS	"DOUBTFUL LIABILITY" CLAIMS
1982	721	7.8%	30.9%
1983	776	12.1	27.4
1984	768	10.2	29.4
1985	937	12.8	29.5
1986	758	12.1	28.6
1987	787	7.2	23.8
TOTAL/AVG.	4,747	10.5%	28.3%

The data does indicate that there are ways in which the cost of frivolous claims may be controlled. St. Paul Companies spent, on average, nearly twice as much per claim on losses and loss adjustment expenses resulting from frivolous claims than did MMIE. MMIE's average loss payment per claim where their evaluation indicated "no liability" was $72 while St. Paul's was $575, almost eight times MMIE's figure. The average allocated LAE cost on the same group of claims was $1,555 at MMIE and $2,559 at St. Paul. The total cost of the average frivolous claim at MMIE then was $1,627 and the comparable cost at the St. Paul was $3,134. The difference between companies was greater when comparing the "doubtful liability" category where St. Paul's total loss and loss adjustment expense costs were 2.4 times those of MMIE.

N. Company Comparison

A comparison of the experience of the two companies examined is pertinent because of their differing management structures and organizations. Physician-run companies such as MMIE have been criticized nationally by the commercial insurance industry for poor management and the use of artifically low rates.

However, the study data indicates that MMIE's claims management is, in fact, more efficient than St. Paul's. For example, St. Paul Companies spent on average more than twice as much in allocated loss adjustment expenses per claim compared to MMIE. The St. Paul also paid a higher average loss per claim, one and one half times

the average loss payment of MMIE. The companies also differed in the amount of time needed to close a claim. This trend is particularly evident in recent years where, in 1986 and 1987, MMIE has closed approximately 20 percent more of their total claim files in each year than St. Paul has.

Tables 17 and 18 compare allocated LAE, average loss payments and the percentages of total claims that have been closed, by year, for each company.

TABLE 17: MMIE LOSS EXPERIENCE

REPORT YEAR	TOTAL FILES	PERCENT CLOSED	AVERAGE LOSS PAYMENT	AVERAGE LAE
1982	298	99.7%	$15,795	$3,577
1983	347	95.4	7,714	1,952
1984	380	90.5	10,357	1,855
1985	464	87.7	11,481	1,986
1986	355	79.4	14,156	1,289
1987	407	42.5	6,650	383
TOTAL/AVG.	2,251	81.5%	$11,245	$1,955

TABLE 18: ST. PAUL COMPANIES LOSS EXPERIENCE

REPORT YEAR	TOTAL FILES	PERCENT CLOSED	AVERAGE LOSS PAYMENT	AVERAGE LAE
1982	423	95.3%	$28,147	$6,205
1983	429	95.6	12,622	3,838
1984	388	87.9	24,771	5,723
1985	473	79.5	15,892	4,248
1986	403	58.1	5,294	2,279
1987	380	23.9	9,259	2,494
TOTAL/AVG.	2,496	74.3%	$17,802	$4,519

V. FAILURE OF COMPETITIVE RATING IN "NICHE" MARKETS

Medical liability underwriting requires a high degree of expertise that takes time and money to develop. There are a number of reasons why it is not feasible for insurers to move in and out of the medical liability market in the same way they may enter and exit other, less complex liability insurance markets.

First, accurate and comprehensive data is not available to potential insurers. The same type of loss information found in this report is necessary for an insurer contemplating market entry to make an informed decision. The insurance industry has its own data gathering organizations such as the Insurance Services Office (ISO). Neither St. Paul Companies nor MMIE, however, report medical malpractice loss experience to ISO. Thus, the data published by ISO for this line of insurance lacks credibility, at least with respect to Minnesota experience. In addition, neither the state or federal government has obtained the necessary loss data. The result has been a significant information gap and consequently, a competitively weak market.

Second, the number of purchasers in specialty markets such as medical malpractice are not sufficient to generate substantial number of competing vendors. Insurers must insure large numbers of policyholders to spread risks. Just as airlines cannot sustain long term competition in niche markets where there is limited market demand, the limited number of policyholders in the malpractice market makes it clear that new competitors will not likely survive market entry against a well established and financial competitor.

Third, the demand for malpractice insurance is highly inelastic. Unlike other lines of insurance where coverage type, policy limits or coverage needs vary and may provide a basis for non-price competition, competition in the physician malpractice market is based almost solely on price. A potential new insurer cannot create a market niche by offering a unique product. There is little variation in coverage types and policy limits are frequently determined by a physician's employer or by hospitals where a physician has privileges. Physicians are unlikely to buy more coverage than what is required regardless of the price. Perhaps the only non-price competitive base is a "good reputation" particularly with respect to defending and paying claims, something that a new insurer entering the market could not readily acquire.

Thus, the degree of specialization required for successful underwriting of medical malpractice necessitates that a new insurer quickly build a significant volume of business not only to spread risk but to justify the high cost of entering such a specialized market. An insurer like St. Paul Companies that has been in the market for over 50 years has an overwhelming advantage in terms of access to long-term loss data as well as the company's long-standing reputation and underwriting expertise.

MMIE's successful entry into the market is likely a product of the built-in expertise of its physician management and the market draw of its original organizational structure as a mutual-type company. MMIE has succeeded in keeping their rates below St. Paul's and has managed claims in a more cost-effective manner.

It is obvious that insurers are charging considerably higher rates than are necessary to cover losses and expenses and also realize a healthy profit. The ratemakers have not accounted for the historically consistent disparity between actual loss payments and loss reserves. Indeed, the data on file indicates that when all claims are closed, the 1985-87 loss ratios will be substantially lower than than the 80-85 percent range targeted by the carriers. Indeed, when the reserves are properly calculated, the loss ratio will likely be under 50 percent.

VI. CONCLUSIONS

° With the exception of self-insured groups, the St. Paul Companies and Minnesota Medical Insurance Exchange insure nearly 100 percent of Minnesota's physicians. Thus, this report's data represents the only known comprehensive study of physician loss experience for any jurisdiction over the last six years.

° The frequency of claims per year has not materially changed over the past six years.

° The severity of the claims payment has not materially changed over the six year period.

° Fewer than one-half of one percent of all malpractice claimants are awarded damages by a jury. Most important, this figure has remained constant over the period of the study;

° Claims determined by the insurer to be frivolous have not increased over the past six years.

° The likelihood of receiving compensation as a result of filing a malpractice claim is approximately 25 percent. This rate has not materially changed over the period of the study;

° No punitive damages were found to be awarded against a physician.

° The average cost of investigation and defending a claim has changed little in the last six years. Indeed, the amount appears to be decreasing; and

° Despite unchanging claim frequency and declining loss payments and loss expense, on average, physicians paid approximately triple the amount of premiums for malpractice insurance in 1987 than in 1982.

VII. RECOMMENDATIONS

° An independent government agency should periodically conduct claims examinations in specialty lines of insurance.

° The data collected and compiled as a result of these examinations shall be made readily available to the public. This would:

* enable competing insurers to recognize competitively weak markets to enter.

* enable public policy makers to debate insurance and liability issues with credible statistics.

* enable the regulators to address difficulties with pricing and availability of coverage.

° On the basis of the data collected through such examinations, the government should review and, if necessary, regulate the premium.

° When the market become less competitive, the government should establish underwriting pools to make coverage available. The rates charged by these pools, however, should not undercut or discourage a competitive market.

PHYSICIANS' AND SURGEONS' PROFESSIONAL LIABILITY INSURANCE POLICY

INDIVIDUAL PROFESSIONAL LIABILITY INSURANCE

PARTNERSHIP/PROFESSIONAL ASSOCIATION/BUSINESS TRUST/PROPRIETORSHIP PROFESSIONAL LIABILITY INSURANCE

PROFESSIONAL PREMISES LIABILITY INSURANCE

MINNESOTA
mie
MINNESOTA MEDICAL INSURANCE EXCHANGE

MMIE IS A "RECIPROCAL" INSURANCE COMPANY

TO OUR POLICYHOLDERS

This is a "claims-made" Policy. It only covers claims arising from the performance of **Professional Services** subsequent to the retroactive date indicated on the Declarations Page attached hereto and then only during the effective provisions of the Policy while the Policy is in force. No coverage is afforded for claims first made prior to the effective date of this Policy, and no coverage is afforded for claims first made after the termination of this Policy unless and to the extent that reporting endorsements are purchased in accordance with Article IV, Section (c) of this Policy. Please review the Policy carefully.

MINNESOTA MEDICAL INSURANCE EXCHANGE

222' [illegible]
[illegible]
612 623 ''32 • 800 [illegible]

PROFESS[illegible]
PROFESSIONAL PREMISES [illegible]

Name and Address of Insured

Policy Number

In consideration of the required premium the policy is effective from to

12:01 A.M. standard time at the address of the Named Insured as stated

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Insurance is afforded only with respect to the Coverage Part(s) for which a premium charge or NO CHARGE is indicated. The limit of MMIE's liability shall be as stated, subject to all the provisions of the policy, attached hereto.

PART I PROFESSIONAL LIABILITY INSURANCE

( ) Individual Professional Liability

( ) Partnership, Corporation, Professional Association or Business Trust Professional Liability

Limits of Liability

each claim

aggregate

The Insured's principal specialty is.

The Insured's Basic Retroactive Date is

SAMPLE

Class

Premium

Individual Professional Liability

Partnership, Corporation, Professional Association or Business Trust Professional Liability

Paramedical Personnel Coverage

Endorsements Part I

PART II PROFESSIONAL PREMISES LIABILITY COVERAGES

Injury Limits each occurrence Property Damage Limits each occurr[illegible]

Location Address

Prem[illegible]

1

2

3

4

Endorsements Part II

Total Policy Premium

Issued by Minnesota Medical Insurance Exchange
(A Reciprocal Insurance Company, organized in the State of Minnesota, herein called MMIE)
Issue Date

Authorized Representative

The Interstate Medical Insurance Exchange (MMIE) in consideration of the payment of the premium and in reliance upon the representations and warranties contained in the application, made a part hereof, and subject to all of the provisions of this Policy, with the person named on the Declarations Page the "Named Insured" as follows:

I. INSURING AGREEMENTS

PART I - PHYSICIANS AND SURGEONS PROFESSIONAL LIABILITY INSURANCE

Individual Professional Liability: To pay on behalf of the Named Insured all sums which the **Named Insured** shall become legally obligated to pay as **Damages** because of any claim or claims first made against the **Named Insured** during the **Policy Period** arising out of the performance of **Professional Services** rendered or which should have been rendered subsequent to the retroactive date in the practice of the Named **Insured's** profession as a physician, by the **Named Insured** or by any person for whose acts or omissions the **Named Insured** is legally responsible, except when such legal responsibility is related to the **Named Insured's** status as a member of a Partnership, Professional Association, Business Trust or Proprietorship.

Partnership, Professional Association, Business Trust or Proprietorship Professional Liability: To pay on behalf of the **Named Insured** all sums which the Named Insured shall become legally obligated to pay as **Damages** because of any claim or claims first made against the **Named Insured** during the **Policy Period** arising out of the performance of **Professional Services** rendered or which should have been rendered subsequent to the retroactive date in the practice of the profession of physician by any person for whose acts or omissions the **Named Insured** Partnership, Professional Association, Business Trust or Proprietorship is legally responsible.

MMIE shall have the right and duty to defend any suit against the **Named Insured** alleging such **Damages**, even if any of the allegations of the suit are groundless, false, or fraudulent, and may make such investigation or such settlement of any claim or suit as it deems expedient, but MMIE shall not be obligated to pay any claim or judgment or to defend any suit after the applicable limit of MMIE's liability has been exhausted by payment of judgments or settlements.

Exclusions:

Part I does not apply:

a to liability of any **Named Insured** as a proprietor, partner, shareholder, executive officer, administrator, committee member, director, or medical director of any hospital, sanitarium, infirmary, clinic with bed and board facilities, nursing home, abortion clinic, drug abuse clinic, surgi-center, blood bank, commercial laboratory, **Health** Maintenance Organization, preferred provider organization or other **professional** or business enterprise, but with respect to the term commercial **laboratory** this exclusion does not apply to laboratory facilities maintained or used for testing of the Named **Insured's** own patients nor to an x-ray or pathological laboratory if the Named Insured is a radiologist or pathologist;

b to liability of any **Named Insured** when any **Named Insured** is enrolled in, and rendering **Professional Services** pursuant to, a bona fide medical or surgical training program;

c to liability of others assumed by any **Named Insured** under contract or agreement;

d to any obligation for which any **Named Insured** or any carrier as his insurer may be held liable under any workmen's compensation, unemployment compensation or disability benefits law or under any similar law;

e to liability of any Named Insured for Damages resulting from any act or omission as a violation of any state, ordinance or regulation imposing criminal liability, including punitive damages;

f to liability of any Named Insured for any punitive Damages;

g to liability of any Named Insured arising out of acts or omissions which occur at any time the Named Insured's license to practice medicine has been suspended, revoked or voluntarily surrendered;

h to liability of any Named Insured arising out of acts or omissions of an Employed Physician which occur during any time such Employed Physician's license to practice medicine has been suspended, revoked or voluntarily surrendered;

i to liability of any Named Insured for Damages arising out of the dispensing or prescribing of controlled substances by any Named Insured during any time such Named Insured's controlled substance registration has been suspended, revoked or surrendered;

j to liability of any Named Insured for Damages arising out of the dispensing or prescribing of controlled substances by any Employed Physician during any time such Employed Physician's controlled substance registration has been suspended, revoked or voluntarily surrendered;

k to liability of any Named Insured for Damages with respect to:

(1) any claim made against any Named Insured at any time during any Prior Policy Period, regardless of whether or not such claim has been reported to any applicable liability insurer;

(2) any potential claim against any Named Insured of which any Named Insured is aware, or reasonably should have been aware, as of the date this Policy is issued, regardless of whether or not such claim has yet been made or reported to any applicable liability insurer. For purposes of this section (k)(2), potential claim includes without limitation instances where any Named Insured has received either an oral or written communication from a patient or his legal representative, and/or a request by a patient or his legal representative for copies of medical records under circumstances reasonably indicative of a potential claim;

(3) any claim based, in whole or in part, upon any act or omission of the Named Insured while outside the territorial United States and Canada.

PART II - PROFESSIONAL PREMISES LIABILITY

To pay on behalf of the Named Insured all sums which the Named Insured shall become legally obligated to pay as Damages because of:

BODILY INJURY,
PROPERTY DAMAGE, or
PERSONAL INJURY

caused by an Occurrence and arising out of the ownership, maintenance or use, as a Professional Office, of the Insured Premises and all operations necessary or incidental thereto, and MMIE shall have the right and duty to defend any claim or suit against the Named Insured alleging Damages, even if such suit is groundless, false or fraudulent, and may make such investigation and settlement of any claim or suit as it deems expedient, but MMIE shall not be obligated to pay any claim or judgment or to defend any suit after the applicable limit of MMIE's liability hereunder has been exhausted by payment of judgments or settlements.

Exclusions:

Part II does not apply:

a to **Bodily Injury** or Property Damage arising out of the ownership, operation, use, loading or unloading of
(1) any automobile, aircraft or other air, sea or land vehicle owned or operated by or rented or loaned to the **Named Insured**, or
(2) any other automobile, aircraft or other air, sea or land vehicle operated by any person in the course of his employment by the **Named Insured**;
(3) this exclusion does not apply to the parking of an automobile on the Named **Insured's professional office premises**, if such automobile is not owned by or rented or loaned to the **Named Insured**;

b) to any obligation for which the **Named Insured** or any carrier as his insurer may be held liable under any worker's compensation, unemployment compensation or disability benefits law, or under any similar law;

c) to **Bodily Injury** to any agent or employee, partner, fellow worker or tenant of the **Named Insured** arising out of and in the course of his engagement or employment by the **Named Insured**;

d) to **property damage** to
(1) property owned or occupied by or rented to the **Named Insured**,
(2) property used by the **Named Insured**, or
(3) property in the care, custody or control of the **Named Insured** or as to which the **Named Insured** is for any purpose exercising physical control;
but part (3) of this exclusion does not apply with respect to **property damage**, other than to elevators, arising out of the use of an elevator at the insured premises;

e) to **Bodily Injury** or **Property Damage** due to nuclear reaction, nuclear radiation or radioactive contamination or escape of pollutants, or to any act or condition incident to any of the foregoing;

f) with respects to **Personal Injury**, to liability assumed by the **Named Insured** under any contract or agreement;

g) to liability of any **Named Insured** for **Personal Injury** resulting from an act or ommission which is a willful violation of a statute, ordinance or regulation imposing criminal penalties (including punitive damages);

h) to **Personal Injury** arising out of any publication or utterance described in Group (2), if the first injurious publication or utterance of the same or similar material by or on behalf of the **Named Insured** was made prior to the effective date of this insurance;

i) to **Personal Injury** arising out of a publication or utterance described in Group (2) of Section IV, a., (2) hereof concerning any organization or business enterprise, or its products or services, made by or at the direction of any **Named Insured** with knowledge of the falsity thereof;

j) to any obligation for which the **Named Insured** may be liable arising out of the **performance of Professional Services.**

k) to **liability** of any **Named Insured** with respect to:
(1) **any claim** made against any **Named Insured** at any time during any **Prior Policy Period**, regardless of whether or not such claim has been reported to any applicable liability insurer;
(2) any potential claim against any **Named Insured** of which any **Named Insured** is aware, or reasonably should have been aware, as of the date this Policy is issued, regardless of whether or not such claim has yet been made or reported to any applicable liability insurer. For purposes of this Section, a., (2), potential claim includes without limitation instances where any **Named Insured** has received either an oral or written communication from a patient or his legal representative, and/or a request by a patient or his legal representative for copies of medical records under circumstances reasonably indicative of a potential claim;

3 arising out of, in whole or in part, upon any act or omission of the Named Insured while the Named Insured is outside the territorial limits of Canada.

SUPPLEMENTARY PAYMENTS

In addition to the applicable limit of liability, MMIE will pay:

a) all expenses incurred by MMIE, all costs taxed against the Named Insured in any suit defended by MMIE and all interest on that part of any judgment which does not exceed the limit of MMIE's liability thereon which accrues after entry of the judgment and before MMIE has paid or tendered or deposited in court such part of the judgment;

b) premiums on appeal bonds required in any suit defended and appealed by MMIE and premiums on bonds to release attachments in any such suit for an amount not in excess of the applicable limit of liability of this Policy, but MMIE shall have no obligation to apply for or furnish any such bonds;

c) expenses incurred by the Named Insured for first aid to others at the time of an accident, for Bodily Injury to which this Policy applies;

d) the reasonable expenses incurred by the Named Insured for each day or part of a day the Named Insured is required to attend the trial of a civil suit against the Named Insured for Damages resulting from causes of action as described under Parts I and II, not in excess of $200.00 per day;

e) if coverage is purchased under Part II, reasonable medical expenses for Bodily Injury sustained by any person which resulted from an Occurrence on the Named Insured's professional office premises, or during any operations necessary or incidental thereto regardless of the Named Insured's liability for such Bodily Injury, and all of which were incurred by the Named Insured within one (1) year from such Occurrence; provided, however, that payments under this provision shall not exceed $1,000 per person and $10,000 per accident, and shall not apply to Bodily Injury:

1 arising out of the ownership, maintenance, operation, use, loading or unloading of

a any automobile, aircraft or other air, sea or land vehicle owned or operated by, or rented or loaned to the Named Insured, or

b any other automobile, aircraft or other air, sea or land vehicle operated by any person in the course of his employment by the Named Insured;

but this exclusion does not apply to the parking of an automobile on the Named Insured's professional office premises, if such automobile is not owned by or rented or loaned to the Named Insured;

2 due to war, whether or not declared, civil war, insurrection, rebellion or revolution or to any act or condition incident to any of the foregoing;

3 to the Named Insured, any agent, employee, fellow worker, partner, tenant or other person regularly residing on the Named Insured's professional office premises, or any employee of any of the foregoing if the Bodily Injury arises out of and in the course of his employment therewith;

4 to any other tenant if the Bodily Injury occurs on that part of the Named Insured's professional office premises rented from the Named Insured or to any agent or employee of such a tenant if the Bodily Injury occurs on the tenant's part of the insured premises and arises out of and in the course of his employment for the tenant;

5 to any person while engaged in maintenance and repair of or alteration, demolition or new construction at the Named Insured's professional office premises;

6 to any person if any benefits for such Bodily Injury are payable or required to be provided under any workers compensation, unemployment compensation or disability benefits law, or under any similar law.

II. DEFINITION OF INSURED

a) The word **Named Insured** shall mean as respects Part II:
   1) under **Individual Professional Liability** each [illegible]
      Page;
   2) under **Partnership, Professional Association, Business Trust** or [illegible]
      Professional Liability the Partnership, Professional [illegible]
      Proprietorship named on the Declarations Page, [illegible]
      respect to [illegible] of others, but [illegible]
      Named Insured with respect to liability for his personal [illegible]
      nature;
   3) any **Paramedical Employee** of the **Named Insured**, while [illegible]
      his employment duties, provided that notice of the employment [illegible]
      Paramedical Employees is given to MMIE when required;
   4) any other employee not a physician or **Paramedical Employee** of the **Named Insured** while acting within the scope of his duties as such.

   The insurance afforded applies separately to each **Named Insured** against [illegible]
   is made or suit is brought except with respect to limits of MMIE's liability [illegible]
   in Article IV, Section b.

b) The word **Named Insured** shall mean as respects Part II:
   the **Named Insured**, and includes any executive officer, director, or [illegible]
   thereof while acting within the scope of his duties as such, and any organization or proprietor with respect to real estate management for the **Named Insured**. If the **Named Insured** is a Partnership, Professional Association, Business Trust or Proprietorship, the unqualified words "**Named Insured**" also include any partner, shareholder, beneficiary or proprietor or member therein but only with respect to his liability as such.

III. POLICY PERIOD - TERRITORY

a) Under Part I the insurance provided hereby only applies to **Professional Services** rendered or which should have been rendered subsequent to the retroactive date stated on the Declarations Page and then only if claim is first made during the **Policy Period** or a **Reporting Period** purchased in accordance with Article IV, Section c.

   A claim shall be considered to be first made when MMIE first receives notice of the claim or of an event which may subsequently give rise to a claim (see Article IV, Section c for **Named Insured's** rights to have extended reporting endorsements issued.

   A claim shall be considered to be "first made during the **Policy Period**" or "first made during a **Reporting Period**" only under the following conditions:
   1) If during the **Policy Period** or a **Reporting Period** if purchased the **Named Insured** shall have knowledge or become aware of any event, arising out of the rendering or failure to render **Professional Services** covered hereby, which may subsequently give rise to a claim and shall, during the **Policy Period** or such **Reporting Period**, give written notice thereof to MMIE in accordance with Article IV, Section [illegible] of this Policy, then such notice shall be considered a claim hereunder;
   2) if any claim is first made during the **Policy Period** or a **Reporting Period** if purchased, alleging injury to an individual that would be covered under this Policy, any additional claims which are made, or suits or proceedings in connection therewith which are brought subsequent to the **Policy Period**

Reporting Period: Damages [illegible] Policy Period [illegible] Reporting Period.

c. Under Part II, the insurance afforded hereby applies to **Bodily Injury**, **Property Damage** or **Personal Injury** which occurs during the **Policy Period** in the territory of United States and Canada.

IV. CONDITIONS

a. **Definitions** - As used in this Policy or Endorsements forming a part hereof:

1. Applicable to Part I:

"Damages" means all Damages, including **Damages** for death, which are payable because of injury to which this insurance applies, including any counter claim made in a suit brought against the **Named Insured** in the process of attempting to collect fees.

"Named Insured" means the person named on the Declarations Page.

"Paramedical Employee" includes medical assistants, technicians including, but not limited to, [illegible] therapy, laboratory and x-ray, nurse anesthetists [illegible] registered nurses, midwives, opticians, [illegible], physical therapists, psychologists, [illegible], nurse practitioners e.g., [illegible] and any other nurse practitioner or nurse employed [illegible] function in the practice of the **Named Insured's** profession.

"Policy Period" means the period of coverage commencing on the date shown on the Declarations Page attached to this Policy as Policy effective date and ending at the effective date of termination, expiration or cancellation of coverage of this Policy, and specifically excludes any **Reporting Period** purchased hereunder.

"Policy Year" means each consecutive annual period of the policy.

"Prior Policy Period" means the period of coverage commencing on the retroactive date shown on the Declarations page attached to this policy and ending upon the date shown as Policy Effective Date.

"Professional Services" means those services performed in the practice of the **Named Insured's** profession as physician including service as 1) a member of any committee of Minnesota Medical Insurance Exchange or Minnesota Medical Management, Inc.; 2) a member of any committee of the American Medical Association or its constituent or component society thereof; 3) a member of any committee of a national medical society recognized by the American Medical Association or its constituent or component society thereof; 4) a member of any committee of any hospital accredited by the Joint Commission on Accreditation of Hospitals or the American Osteopathic Association; 5) a member of any hospital consultation or professional standards review board or committee.

"Reporting Period" [illegible]
[illegible] to be out of Professional Services rendered [illegible] subsequent to the retroactive date and prior to the end of the Policy Period.

"Employed Physician" includes any duly licensed [illegible] employed by the Named Insured.

(2) Applicable to Part II:

"Bodily Injury" means Bodily Injury, sickness or disease or death [illegible] person.

"Damages" means 1 Damages for death and for care and loss [illegible] resulting from Bodily Injury, 2 Damages for loss of use of property [illegible] from Property Damage and 3 Damages which are payable because of Personal Injury.

"Medical Expense" means expenses for necessary medical, surgical, [illegible] dental services, including prosthetic devices, and necessary ambulance, professional nursing and funeral services.

"Named Insured" means the person named on the Declarations Page.

"Occurrence" means an accident, including injurious exposure to conditions, which results, during the Policy Period, in Bodily Injury, Property Damage or Personal Injury neither expected nor intended from the standpoint of the Named Insured.

"Personal Injury" means one or more of the following groups of offenses committed during the Policy Period:

Group 1 false arrest, detention or imprisonment, or malicious prosecution;

Group 2 the publication or utterance of a libel or slander or of other defamatory or disparaging material, or a publication or utterance in violation of an individual's right of privacy, except publications or utterances in the course of or related to advertising, broadcasting or telecasting activities conducted by or on behalf of the Named Insured;

Group 3 wrongful entry or eviction, or other invasion of the right of private occupancy.

"Property Damage" means injury to or destruction of tangible property.

"Professional Office Premises" means (1) the professional office premises designated on the Declarations Page (2) professional office premises alienated by the Named Insured other than premises constructed for sale by the Named Insured, if possession has been relinquished to others, and 3 professional office premises as to which the Named Insured acquires ownership or control and reports his intention to insure such premises under this policy and no other within 30 days after such acquisition and includes the ways immediately adjoining such premises on land.

c. Limits of Liability

1. Under Part I, the limit of liability stated on the Declarations Page as applicable to "each claim" is the limit of MMIE's liability for loss resulting from any claim or suit or claims or suits first made during the Policy Year or Reporting Period because of injury to or death of any one person, subject to the following limits of liability:

If the Named Insured elects for the Reporting Endorsement to apply, the limit of liability stated on the Declarations Page as applicable to "each claim" at the time the Policy or Reporting Period terminates is the limit of MMIE's liability for loss resulting from any one claim or suit or all claims or suits first made during each Reporting Endorsement period or any renewal thereof because of injury to or death of any one person.

Subject to the above provisions respecting "each claim," the limit of liability stated on the Declarations Page as "aggregate" is the total limit of MMIE's liability for all claims or suits first made during the effective Policy Year or during each Reporting Period. If any Reporting Period exceeds one year, the "aggregate" limit of liability applies separately to each consecutive annual period commencing with the effective date of the reporting endorsement.

Regardless of the number of Named Insureds under this Policy the inclusion of more than one Named Insured hereunder shall not operate to increase the limits of MMIE's liability.

2. Under Part II:

The limit of liability stated on the Declarations Page as applicable to "each Occurrence" is the limit of MMIE's liability for all Damages because of Bodily Injury, Property Damage or Personal Injury regardless of the number of 1. Named Insureds under this Policy, 2. persons or organizations who sustain Bodily Injury, Property Damage or Personal Injury, or 3. claims made or suits brought on account of Bodily Injury, Property Damage or Personal Injury. For the purpose of determining the limit of MMIE's liability, all Bodily Injury, Property Damage and Personal Injury arising out of continuous or repeated exposure to substantially the same general conditions shall be considered as arising out of one Occurrence.

d. Reporting Endorsement

Under Part I, in the event of termination of insurance either by non-renewal or cancellation of this Policy or termination of a Reporting Period, the Named Insured shall have the right upon the payment of an additional premium to be computed in accordance with MMIE's rules, rates, rating plans and premiums applicable on the effective date of the endorsement to have issued an endorsement(s) providing additional Reporting Period(s) in which claims otherwise covered by this Policy may be reported. Such right, however, must be exercised by the Named Insured by written notice to MMIE within thirty (30) days after such termination date.

e. Named Insured's Duties in the Event of an Occurrence, Claim, or Suit

1. As soon as the Named Insured obtains knowledge or becoming aware of any alleged Professional Incident which may give rise to a claim, written notice containing the particulars sufficient to identify the insured with respect to the circumstances out of which it arose, including the time, place and address of the injured, the nature and extent of the Professional Services rendered or which should have been rendered and the nature and extent of the injury or claims anticipated, shall be given by or for the

Named Insured to MMIE or any of its authorized representatives as soon as practicable.

2) If claim is made or suit is brought against the **Named Insured**, the Named Insured **shall** immediately forward to MMIE every demand, notice, summons or other process received by him or his representative.

3) The **Named Insured** shall cooperate with MMIE and, upon MMIE's request, assist in making settlements, in the conduct of suits and in enforcing any right of contribution or indemnity against any person or organization who may be liable to the **Named Insured** because of **Bodily Injury, Property Damage** or Personal Injury with respect to which insurance is afforded under this Policy and the Named **Insured** shall attend hearings and trials and assist in securing and giving evidence and obtaining the attendance of witnesses. The **Named Insured** shall not, except at his own cost, voluntarily make any payment, assume any obligation or incur any expense other than for first aid to others at the time of accident.

e. **Action Against MMIE**

No action shall lie against MMIE unless, as a condition precedent thereto, there shall have been full compliance with all of the terms of this Policy, nor until the amount of the **Named Insured's** obligation to pay shall have been finally determined either by final judgment after expiration of period for appeal against the **Named Insured** after actual trial or by written agreement of the **Named Insured**, the Claimant and MMIE.

Any person or organization or the legal representative thereof who has secured such judgment or written agreement shall thereafter be entitled to recover under this Policy to the extent of the insurance afforded by this Policy. No person or organization shall have any right under this Policy to join MMIE as a party to any action against the Named Insured to determine the Named **Insured's** liability, nor shall MMIE be impleaded by the **Named Insured** or his legal representative. Bankruptcy or insolvency of the Named Insured or of the Named Insured's estate shall not relieve MMIE of any of its obligations hereunder.

f. **Other Insurance**

With respect to Part I, if the **Named Insured** has other insurance against a loss covered by this Policy, MMIE shall not be liable under this Policy for a greater proportion of such loss than the limit of liability stated on the Declarations Page bears to the total limit of liability of all valid and collectible insurance against such loss.

With respect to Part II, the insurance afforded by this Policy is primary insurance, **except when stated** to apply in excess of or contingent upon the absence of other **insurance.** When this insurance is primary and the **Named Insured** has other insurance **which is stated** to be applicable to the loss on an excess or contigent basis, the amount of **MMIE's liability** under this Policy shall not be reduced by the existence of such other insurance. When both this insurance and other insurance applies to the loss on the same basis, whether primary, excess or contingent, MMIE shall not be liable under this Policy for a greater proportion of the loss than that stated in the applicable contribution provision below:

(1) **Contribution by Equal Shares**

If all of such other valid and collectible insurance provides for contribution on equal shares, MMIE shall not be liable for a greater proportion of such loss than

applicable if each insurer contributes an equal share until each insurer equals the lowest applicable limit of liability under any one the full amount of the loss is paid and with respect to any amount of loss paid, the remaining insurers continue to contribute equal shares of the remaining amount of the loss until each such insurer has paid its limit in full or the full amount of the loss is paid.

2. Contribution by Limits

If any of such other insurance does not provide for contribution by equal shares, MMIE shall not be liable for a greater proportion of such loss than the applicable limit of liability under this Policy for such loss bears to the total applicable limit of liability of all valid and collectible insurance against such loss.

g. Subrogation

In the event of any payment under this Policy, MMIE shall be subrogated to all the **Named Insured's** rights of recovery therefore against any person or organization excluding, under Part I, employees of the **Named Insured**) and MMIE may require an assignment of such rights from the **Named Insured** to the extent of any payments made under this Policy plus reasonable cost of collection. The **Named Insured** shall execute and deliver instruments and papers and do whatever else is necessary to secure such rights. The **Named Insured** shall do nothing either before or after loss to prejudice such rights and shall cooperate with MMIE in assisting it to protect its rights under this provision. The **Named Insured** acknowledges that MMIE's rights under this provision shall be considered as the first priority claim against any such person or organization, to be paid before any other claims which may exist. MMIE may, at its option, take such action as may be necessary and appropriate to preserve its rights under this provision, including the right to bring suit in the name of the **Named Insured.** MMIE may, at its option, collect such amounts from the proceeds of any settlement or judgment that may be recovered by the **Named Insured** or his legal representative. Any such proceeds of settlement or judgment shall be held in trust by the **Named Insured** for the benefit of MMIE, and MMIE shall be entitled to recover reasonable attorneys' fees from the **Named Insured** incurred in collecting proceeds held by him.

h. Changes

Notice to any representative or knowledge possessed by any representative or by any other person shall not effect a waiver or a change in any part of this Policy or prevent MMIE from asserting any right under the terms of this Policy; nor shall the terms of this Policy be waived or changed, except by endorsement issued to form a part of this Policy. Failure of MMIE to require performance by the **Named Insured** of any **obligations** under this Policy shall not affect its right to require performance of such **obligation.** Any waiver by MMIE of any breach of any provision of this Policy shall not be construed as a waiver of any continuing or succeeding breach of such provision, a waiver or modification of the provision itself, or a waiver or modification of any right under this Policy.

i. Assignment

Assignment of interest under this Policy shall not bind MMIE until its consent is endorsed hereon; if, however, the **Named Insured** shall die, such insurance as is afforded by this Policy shall apply (1) to the **Named Insured's** legal representative, as the **Named Insured**, but only while acting within the scope of his duties as such, and

with respect to the property of the Named Insured. ... temporary custody thereof, as Named Insured, but only until the ... qualification of the legal representative.

j. **Cancellation**

This Policy may be canceled by the **Named Insured** by surrendering ... any of its authorized representatives or by mailing to MMIE written ... when thereafter the cancellation shall be effective. This Policy may be ... MMIE by mailing to the **Named Insured** at the address shown in this Policy ... notice stating a date not less than ten days thereafter when such cancellation ... effective. The mailing of notice as aforesaid shall be sufficient proof of notice. The time of surrender or the effective date and hour of cancellation stated in the notice shall become the end of the **Policy Period**. Delivery of such written notice either by the **Named Insured** or by MMIE shall be equivalent to mailing.

If the **Named Insured** cancels this Policy, earned premium shall be computed in accordance with the customary short rate table and procedures. If MMIE cancels, earned premium shall be computed pro-rata. Premium adjustment may be made either at the time cancellation is effected or as soon as practicable after cancellation becomes effective, but tender by MMIE of unearned premium is not a condition of cancellation.

This policy may be canceled by MMIE without cause and made retroactive to the inception of the Policy if fraud by the **Named Insured** with regard to the information the **Named Insured** provided MMIE is proved.

k. **Declarations**

By acceptance of this Policy, the **Named Insured** agrees that the statements on the Declarations Page are his agreements and representations, that this Policy is issued in reliance upon the truth of such representations and that this Policy embodies all agreements existing between himself and MMIE or any of its agents relating to this insurance.

l. **Inspection and Audit**

MMIE shall be permitted but not obligated to inspect the **Named Insured's** premises at any time. Neither MMIE's right to make inspections nor the making thereof nor any report thereon shall constitute an undertaking, on behalf of or for the benefit of the **Named Insured** or others, to determine or warrant that such premises are safe or healthful, or are in compliance with any law, rule or regulation.

MMIE may examine and audit the **Named Insured's** books and records at any time during the **Policy Period** and extensions thereof and within three years after the final termination of this policy, as far as they relate to the subject matter of this insurance.

m. **Governing Law**

The validity, construction and enforceability of this Policy shall be governed in all respects by the law of the State of Minnesota or such other states in which the **Named Insured** performs **Professional Services** and MMIE is qualified to sell insurance. Any and all provisions of this Policy which are in conflict with statutes of these states are understood, declared and agreed to be automatically changed to conform to the laws.

n. Assessability

This Policy is non-assessable. The **Named Insured** hereby acknowledges that he has nor other members of MMIE shall be obligated for any debts and liabilities of MMIE.

o. **Severability**

In the event any portion of this Policy shall be held to be invalid, the same shall not affect, in any respect whatsoever, the validity of the remainder of this Policy.

p. **Gender**

Any personal pronoun of the masculine gender used in this Policy shall be deemed to include the feminine gender.

q. **Notices**

Except as otherwise specifically stated in this Policy, all notices or other communications required or contemplated by this Policy shall be addressed:

1) If to MMIE, at its offices;
2) If to the **Named Insured**, at its address stated on the Declarations Page or at such new address as the **Named Insured** may designate by written notice to MMIE.

V. NUCLEAR ENERGY LIABILITY EXCLUSION

A. This Policy does not apply:

1. to injury or death including all forms of radioactive contamination:
   a. with respect to which an **Named Insured** under this Policy is also an **Named Insured** under a nuclear energy liability policy issued by Nuclear Energy Liability Insurance Association, Mutual Atomic Energy Liability Underwriters or Nuclear Insurance Association of Canada, or would be an **Named Insured** under any such policy but for its termination upon exhaustion of its limit of liability; or
   b. resulting from the hazardous properties of nuclear material and with respect to which (1) any person or organization is required to maintain financial protection pursuant to the Atomic Energy Act of 1954, or any law amendatory thereof, or 2) **Named Insured** is, or had this Policy not been issued would be, entitled to indemnity from the United States of America, or any agency thereof, under any agreement entered into by the United States of America, or any agency thereof, with any person or organization.

2. to injury or death including all forms of radioactive contamination resulting from the hazardous properties of nuclear material, if
   a. the nuclear material 1) is at any nuclear facility owned by, or operated by or on behalf of, an **Named Insured** or 2) has been discharged or dispersed therefrom;
   b. the nuclear material is contained in spent fuel or waste at any time possessed, handled, used, processed, stored, transported or disposed of by or on behalf of an **Named Insured**; or

... the ... least arises out of the ... material ... material, parts or equipment ... construction, maintenance, operation or use of ...

B. As used in this exclusion:
"hazardous properties" include radioactive, toxic or ...
"nuclear material" means source material, special ... material;
"source material," "special nuclear material," and "byproduct material" ... meanings given them in the Atomic Energy Act of 1954 or in any ... thereof;
"spent fuel" means any fuel element or fuel component, ... been used or exposed to radiation in a nuclear reactor;
"waste" means any waste material (1) containing byproduct material ... resulting from the operation by any person or organization of any ... included within the definition of nuclear facility as set forth ... paragraph (a) or (b);
"nuclear facility" means
(a) any nuclear reactor.
(b) any equipment or device designed or used for (1) separating the ... uranium or plutonium, (2) processing or utilizing spent fuel, or ... processing or packaging waste.
(c) any equipment or device used for the processing fabricating or ... special nuclear material if at any time the total amount of such material in the custody of the insured at the premises where such equipment or device is located consists of or contains more than 25 grams of plutonium or uranium 233 or any combination thereof, or more than 250 grams of uranium 235.

IN WITNESS WHEREOF, the said Minnesota Medical Insurance Exchange has caused this Policy to be signed by its Chairman, and Secretary, but it shall not be valid unless countersigned on the Declarations Page by a duly authorized representative of MMIE.

Secretary
Minnesota Medical Insurance Exchange

Robert S. Flem

Chairman
Minnesota Medical Insurance Exchange

INTRODUCTION

This policy protects against a variety of losses. There are also some restrictions. We've written the policy in plain, easy-to-understand English. We encourage you to read it carefully to determine what is and is not covered, as well as the rights and duties of those protected.

The words you, your and yours mean the insured named here:

Which is a:

- ☐ corporation
- ☐ individual
- ☐ partnership
- ☐ joint venture
- ☐ other
- ☐ condominium

We, us, our and ours mean the **St. Paul Fire and Marine Insurance Company**. We're a capital stock company located in St. Paul, Minnesota.

Your policy is composed of General Rules, an explanation of What To Do If You Have A Loss, one or more Coverage Summaries, and one or more Insuring Agreements explaining your coverage. It may also include one or more endorsements. Endorsements are documents that change your policy. The agreements and endorsements included when this policy begins are listed below. One of our authorized representatives must also countersign the policy before it is valid.

This policy will begin on_____
and continue until_____
Your former policy, number _____
is automatically cancelled on the date this policy begins.

In return for your premium, we'll provide the protection stated in this policy.
Your premium is_____

Forms Included When This Policy Begins

Form number and edition date

Our authorized representative is:

President Secretary

Authorized Representative Date

The St. Paul

Important Note: This is a claims made coverage. Please read it carefully, especially the When a Claim Is Made and Optional Reporting Endorsement sections

Physicians' Professional Liability Protection–Claims Made

Policy issued to	Agreement takes effect	Policy number

How this agreement protects you

This agreement provides protection against professional liability claims which might be brought against you in your practice as a physician or surgeon.

Who's protected under this agreement

Name	Retroactive Date	Name	Retroactive Date
Name of Covered Professional Organization			

Each person and organization named above or in the "Who's protected" section of the Introduction page is covered under this agreement. The words you, your and yours refer to these people or this organization.

Limits of your coverage

Two limits apply to the amount we'll pay for professional claims. These limits are shown below or on the Introduction page. The limits apply separately to each covered person. When an organization is also covered, the limits apply separately to that organization.

$ _____ Each person limit. This is the most we'll pay for all claims resulting from the injury or death of any one person.

$ _____ Total limit. This is the most we'll pay for all claims first made in a policy year. By policy year we mean each consecutive annual period of the policy. If no total limit is shown, the total limit is 3 times the each person limit.

When you're covered

To be covered the professional service must have been performed (or should have been performed) after your retroactive date that applies. The claim must also first be made while this agreement is in effect.

When is a claim made?

A claim is made on the date you first report an incident or injury to us or our agent. You must include the following information:

- Date, time and place of the incident
- What happened and what professional service you performed.
- Type of claim you anticipate.
- Name and address of injured party
- Name and address of any witness.

What this agreement covers

Individual coverage. Your professional liability protection covers you for damages resulting from
1. Your providing or withholding of professional services.

This agreement must be signed only when it's issued after the effective date of the policy.

Authorized Representative

These rules apply to the entire policy unless you're notified otherwise.

Special Rights And Duties Of The First Named Insured

You agree that when more than one insured is named in the introduction, the first named insured has special rights and duties. These rights and duties are explained in the following General Rules:

- Premiums.
- Cancellation.
- Policy Changes.

Your Policy Period

Insuring agreements in this policy begin at 12:01 a.m., standard time, on the effective date. If this policy replaces policies ending at noon, rather than 12:01 a.m., coverage begins at noon when the old policy ends.

Insuring agreements added to this policy after its effective date begin on the effective date of the added agreement.

Coverage ends at 12:01 a.m., standard time, on the expiration date. If all or part of this policy is cancelled for any reason before that date, that coverage will end at 12:01 a.m., standard time, on the cancellation date.

Premiums

We compute the premium you pay for this policy using information available at the time. So, all or part of your premium may be based on estimates. If estimates are used, we'll compute your actual premium when complete information is available at the end of the policy period. If it's more than you've paid, you'll owe us the difference. If it's less, we'll return the difference. But you won't pay less than any minimum annual premium agreed on. The first named insured is responsible for paying all premiums and will be the one to whom we'll pay any return premiums.

You must keep accurate records of the information we'll need to compute your premium. Your agent can explain the type of records we'll need. The first named insured agrees to send copies of these records at the end of each policy period - or any other time we request them.

Our Right To Inspect And Audit

You agree to let us inspect your property and business operations during normal business hours while this policy is in force. We're not, however, required to make inspections. Nor will we guarantee that your property or operations are safe, or that they conform to any laws, codes, standards or regulations. This rule also applies to any organization which makes insurance inspections, surveys, reports or recommendations for us.

You also agree to let us examine and audit your financial books and records that relate to this insurance at any time up to 3 years after this policy ends.

Policy Changes

This policy contains all the agreements between you and us concerning this insurance. The first named insured is authorized to make changes in this policy with our consent. This policy can only be changed by a written form included as part of the policy. This form must be signed by one of our authorized representatives.

We make changes in our standard insurance policy forms from time to time. These changes must conform to state law and are filed with insurance supervisory authorities for approval. While your coverage is in force we can make any change in the form of this policy that broadens or extends your coverage. If we do, and the change can be added to your policy without increasing the premium, you'll automatically receive the benefit of the extended or broadened

Lawsuits Against Us

No one can sue us to recover under this policy unless all of its terms have been lived up to.

If your policy includes property insurance. Any lawsuit to recover on a property claim must begin within 2 years after the date on which the direct physical loss or damage occurred. State law gives you more time for property located in these states:
•North Dakota, North Carolina,
Maryland - 3 years;
•Wyoming - 4 years; and
•Kansas, Nebraska - 5 years.

If your policy includes liability insurance. No one can sue us on a liability claim until the amount of the protected person's liability has been finally decided either by a trial or by a written agreement signed by the protected person, by us and by the party making this claim. Once liability has been determined by judgment or by written agreement, the party making the claim may be able to recover under this policy, up to the limits of coverage that apply. But that party can't sue us directly or join us in a suit against the protected person until liability has been so determined.

If the protected person or his or her estate goes bankrupt or becomes insolvent, we still will be obligated under this policy.

Provision Required By Law

"This policy is issued under and in pursuance of the laws of the State of Minnesota, relating to Guaranty Surplus and Special Reserve Funds, Chapter 437, General Laws of 1909. (This provision applies only if this policy is issued in the St. Paul Fire and Marine Insurance Company.)

Loss Or Damage To Covered Property

If an accident or incident causes a property loss that's covered under this policy you must:

1. Notify the police if a law may have been broken.

2. Tell us or our agent what happened as soon as possible. Include the time and place of the event, a description of the property and the names and addresses of any witnesses.

3. Do what is reasonable and necessary to protect covered property from further damage. Keep a record of your expenses for consideration in your claim.

4. If feasible, separate the damaged property from the undamaged and make an inventory of the damaged items. This doesn't apply to Auto insurance if included in your policy.

5. Cooperate with us in the investigation and settlement of the claim. Show us the damaged property and any records you have to prove your loss at such times as may reasonably be required. Also permit us to take samples of damaged property for inspection, testing, and analysis. If your loss involves a covered auto, permit us to inspect the auto before it is repaired or disposed of.

6. Allow us to question you under oath at such times as may be reasonably required about any matter relating to this insurance or your claim, including your books and records. If we do, you agree to sign a copy of your answers.

7. Send us a signed, sworn statement of loss containing the information we request to investigate the claim. You must do this within 60 days after our request. We'll supply the forms. We'll pay within 30 days after we reach agreement with you.

Someone Is Injured Or Something Happens Which Can Result In A Liability Claim

If an accident or incident occurs that may involve this policy, you or any other protected person involved must:

1. Notify the police if a law may have been broken.

2. Tell us or our agent what happened as soon as possible. Do this even though no claim has been made but you or another protected person is aware of having done something that may later result in a claim. This notice should include:
- The time and place of the event;
- The protected person involved;
- The specific nature of the incident including the type of claim that may result; and
- The names and addresses of any witnesses and injured people.

Important Exception For Hospitals
If Professional Hospital Liability Protection - Claims Made is included in this policy, we won't consider a "Patient Incident Report" or "Variance Report" to be your report of a claim made - even if you send it to us or one of our agents.

3. Send us copies of all demands or legal documents if someone makes a claim or starts a lawsuit.

4. Cooperate and assist us in securing and giving evidence, attending hearings and trials, and obtaining the attendance of witnesses.

5. Not assume any financial obligation or pay out any money without our consent. But this rule doesn't apply to first aid given to others at the time of an accident.

PREJUDGMENT INTEREST ENDORSEMENT

St Paul

This endorsement changes your:

How Your Coverage Is Changed

Your Liability Protection is changed by adding the following to the Additional Benefits section.

Prejudgment Interest. We'll pay the prejudgment interest awarded on that part of any judgment we pay. But if we make an offer to pay the limit of coverage that applies, we won't pay the prejudgment interest that accumulates after the date of our offer.

Other Terms

All other terms of your policy remain the same.

COMBINED COMPANIES
LOSS EXPERIENCE
MINNESOTA

REPORT YEAR	QUANTITY CLAIMS	EARNED PREMIUM	PAID LOSS	PAID LOSS EXPENSE	OUTSTANDING LOSS RESERVE	OUTSTANDING LOSS EXP.	TOTAL LOSSES and RESERVES	LOSS RATIO
1982	595	$17,889,490	$13,579,982	$ 2,566,569	$ 1,840,000	$ 177,822	$ 18,164,373	101.5%
1983	660	21,186,512	6,584,010	1,888,960	2,890,501	458,015	11,821,492	55.8
1984	662	25,677,303	9,324,311	2,267,169	7,850,000	1,266,545	20,708,025	80.6
1985	811	34,469,869	9,170,537	2,756,639	16,608,353	2,311,973	30,847,502	89.5
1986	635	45,306,249	3,280,682	1,282,389	21,075,356	4,123,340	29,761,767	65.7
1987	659	55,612,065	1,157,647	454,174	26,701,391	5,812,193	34,125,405	61.4
TOTALS	4,022	$200,141,488	$43,097,175	$11,215,900	$76,965,601	$14,149,888	$145,428,564	72.7%

COMBINED COMPANIES
LOSS EXPERIENCE
NORTH DAKOTA

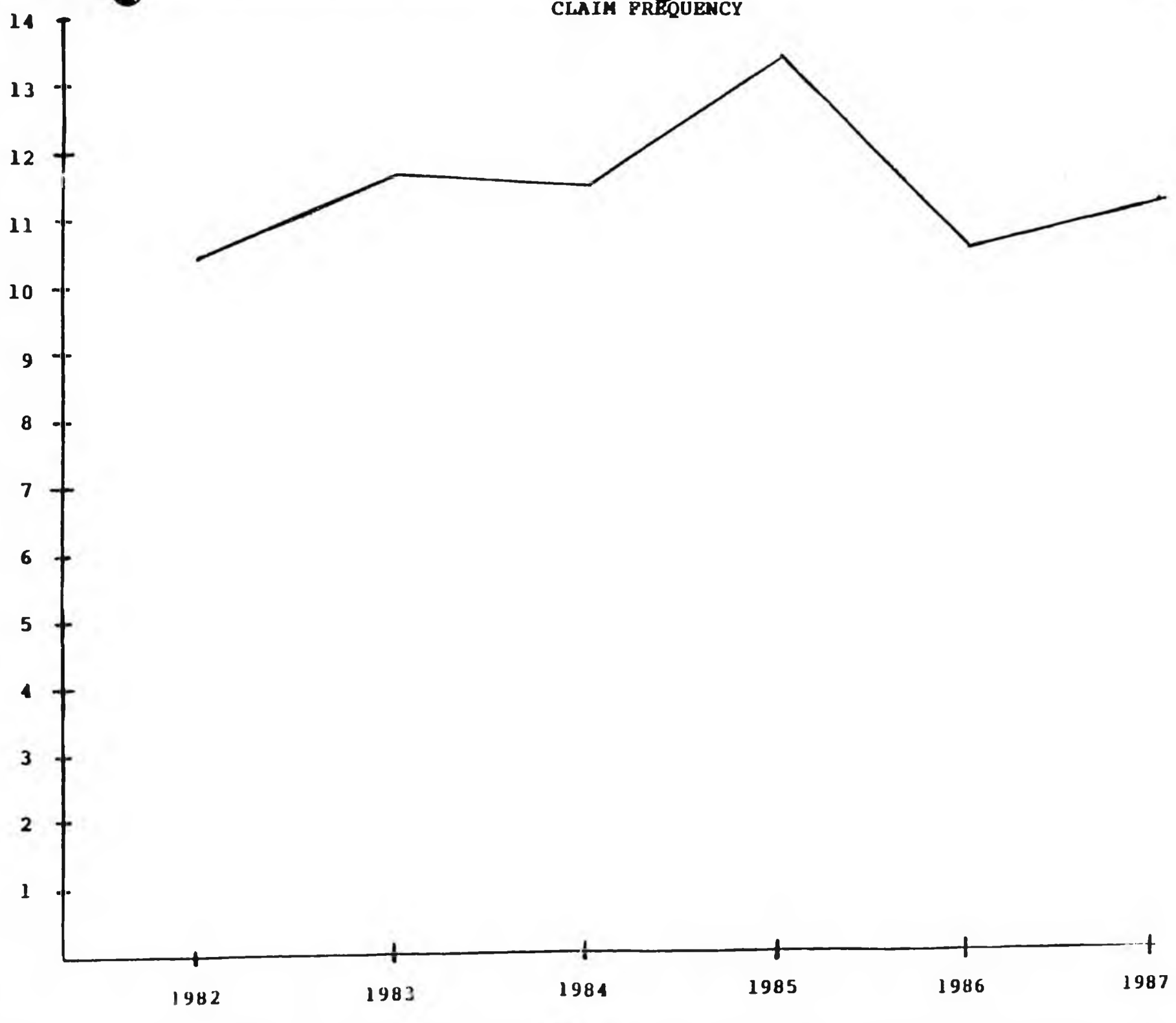
REPORT YEAR	QUANTITY CLAIMS	EARNED PREMIUM	PAID LOSS	PAID LOSS EXPENSE	OUTSTANDING LOSS RESERVE	OUTSTANDING LOSS EXP.	TOTAL LOSSES and RESERVES	LOSS RATIO
1982	77	$ 2,907,823	$1,152,407	$ 921,361	$ 645,000	$ 91,328	$ 2,810,096	96.6%
1983	66	3,298,398	931,254	507,344	125,000	16,718	1,580,316	47.9
1984	58	3,939,474	2,459,148	1,155,779	880,000	144,862	4,639,789	117.8
1985	67	5,116,721	846,894	663,964	2,126,000	211,323	3,848,181	75.2
1986	69	6,569,294	1,399,882	616,777	3,100,000	1,004,435	6,121,094	93.2
1987	76	9,222,907	149,950	195,066	4,958,000	552,172	5,855,188	63.5
TOTALS	413	$31,054,617	$6,939,535	$4,060,291	$11,834,000	$2,020,838	$24,854,664	80.0%

COMBINED COMPANIES
LOSS EXPERIENCE
SOUTH DAKOTA

REPORT YEAR	QUANTITY CLAIMS	EARNED PREMIUM	PAID LOSS	PAID LOSS EXPENSE	OUTSTANDING LOSS RESERVE	OUTSTANDING LOSS EXP.	TOTAL LOSSES and RESERVES	LOSS RATIO
1982	49	$ 2,572,536	$1,301,980	$ 345,782	$ 70,000	$ 20,855	$ 1,738,617	67.6%
1983	50	2,455,518	214,614	117,394	25,000	73,791	430,799	17.5
1984	48	2,873,114	226,205	123,179	50,000	19,630	419,014	14.6
1985	59	3,864,849	630,623	456,637	940,000	183,685	2,210,945	57.2
1986	54	5,126,260	550,282	172,648	2,944,500	509,662	4,177,092	81.5
1987	52	6,509,527	685,474	111,813	996,500	552,165	2,345,952	36.0
TOTALS	312	$23,401,804	$3,609,178	$1,327,453	$5,026,000	$1,359,788	$11,322,419	48.4%

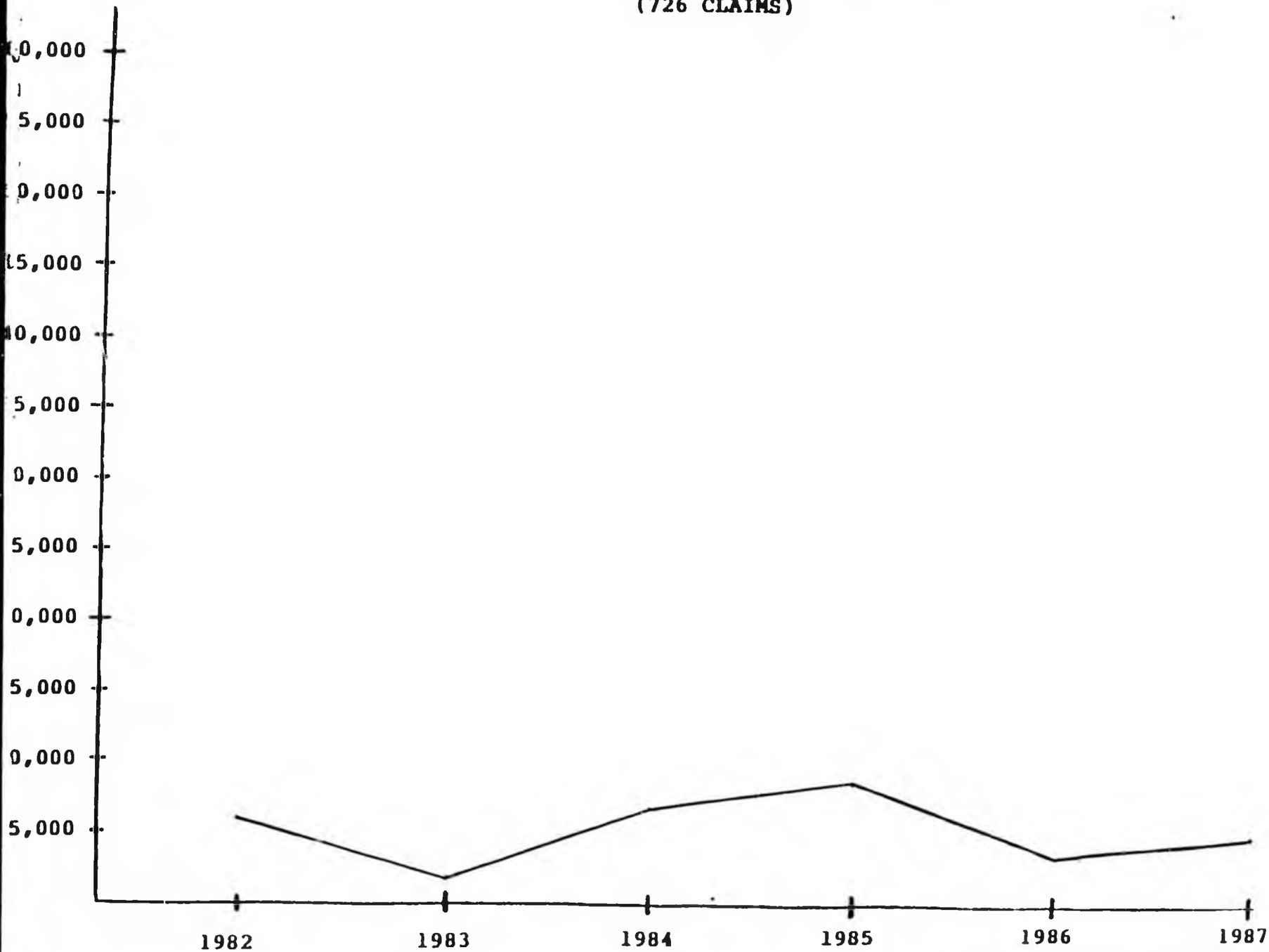
LOSS PAYMENT AND OPEN RESERVE DISTRIBUTION COMPARISON

Payment/Reserve Distribution	Number of Payments (Closed Claims)	Number of Reserves (Open Claims)
$ - 0	2,707	0
1 - 999	82	55
1,000 - 4,999	182	28
5,000 - 14,999	199	165
15,000 - 24,999	111	109
25,000 - 49,999	151	145
50,000 - 99,999	112	179
100,000 - 249,999	97	157
250,000 - 499,999	33	97
500,000 - 999,999	12	26
1,000,000 - Over	3	8
Unknown	0	89
TOTAL	3,689	1,058


CLAIM FREQUENCY
14
13
12
11
10
9
8
7
6
5
4
3
2
1
1982
1983
1984
1985
1986
1987

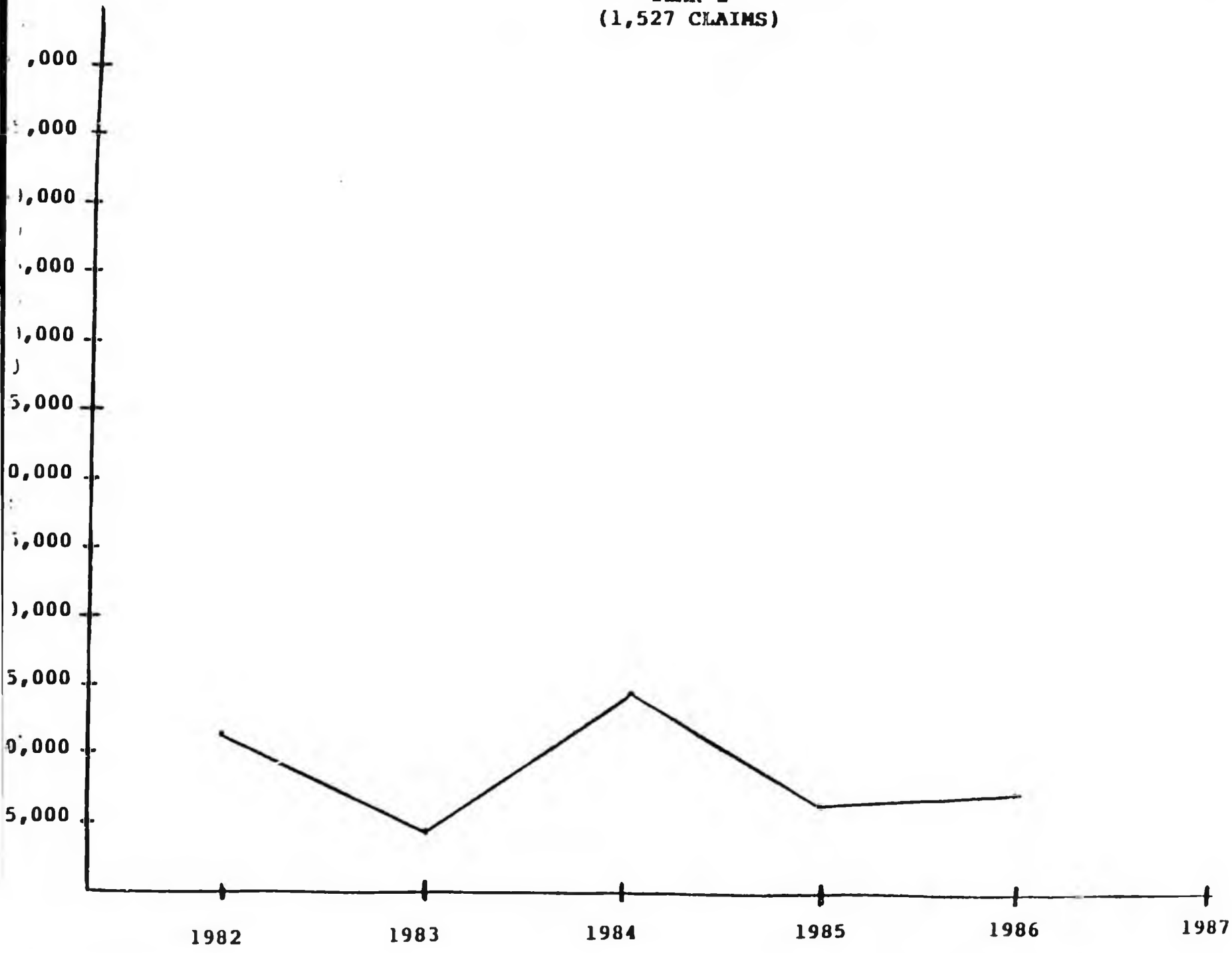
APPENDIX D-1

CLAIM SEVERITY AT
EQUAL LOSS DEVELOPMENT YEARS
YEAR 1
(726 CLAIMS)



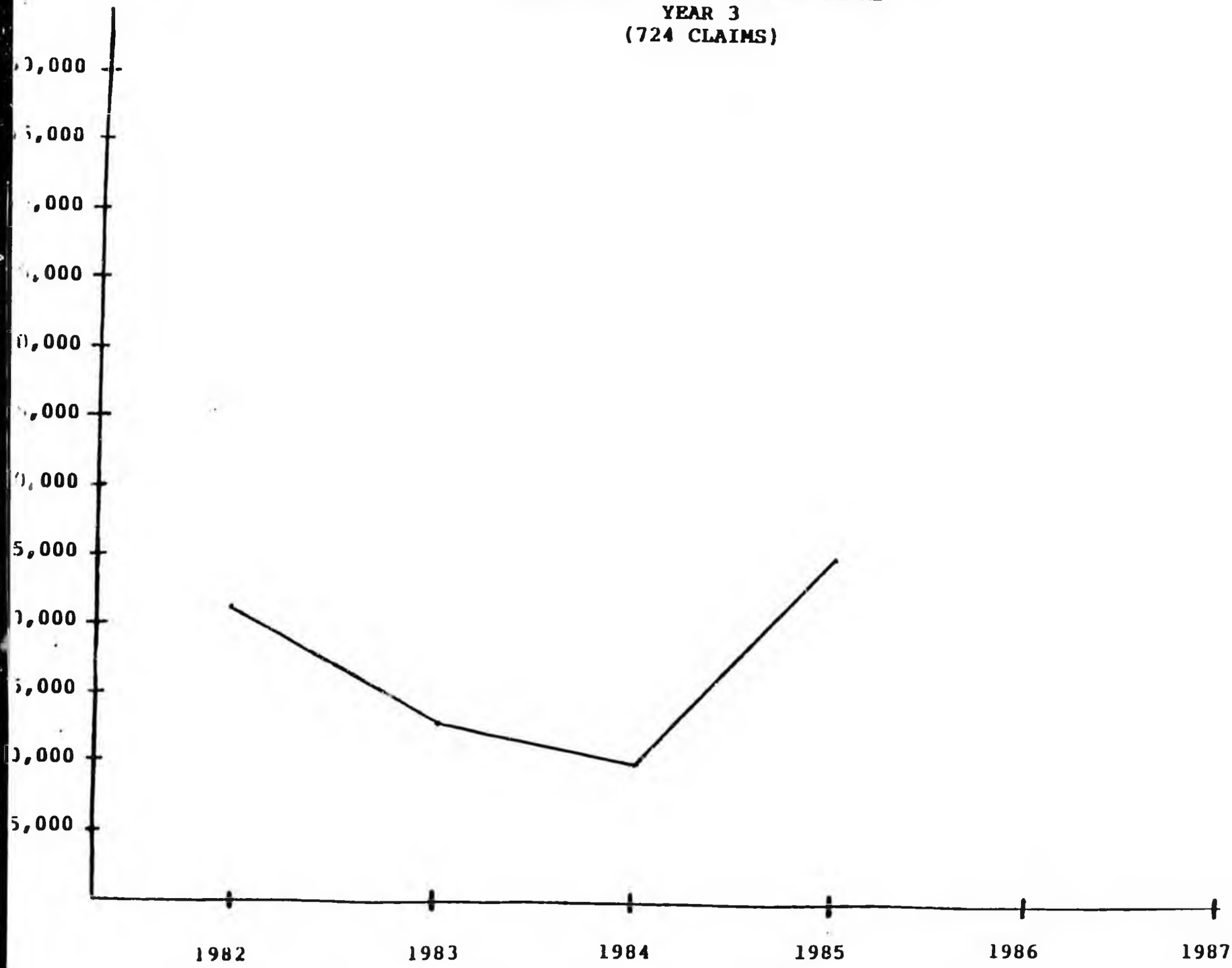
APPENDIX D-2

CLAIM SEVERITY AT
EQUAL LOSS DEVELOPMENT YEARS
YEAR 2
(1,527 CLAIMS)



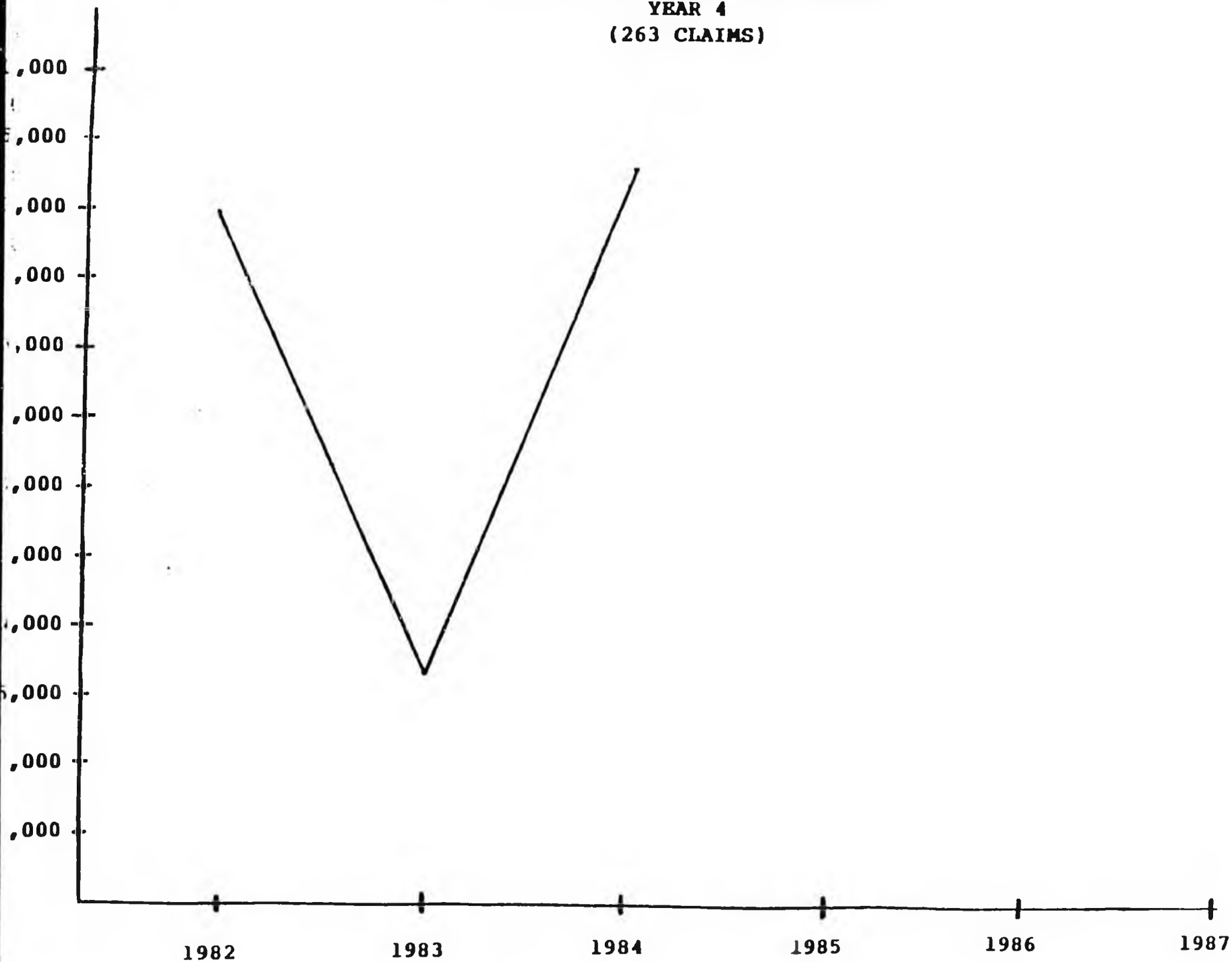
APPENDIX D-3

CLAIM SEVERITY AT
EQUAL LOSS DEVELOPMENT YEARS
YEAR 3
(724 CLAIMS)



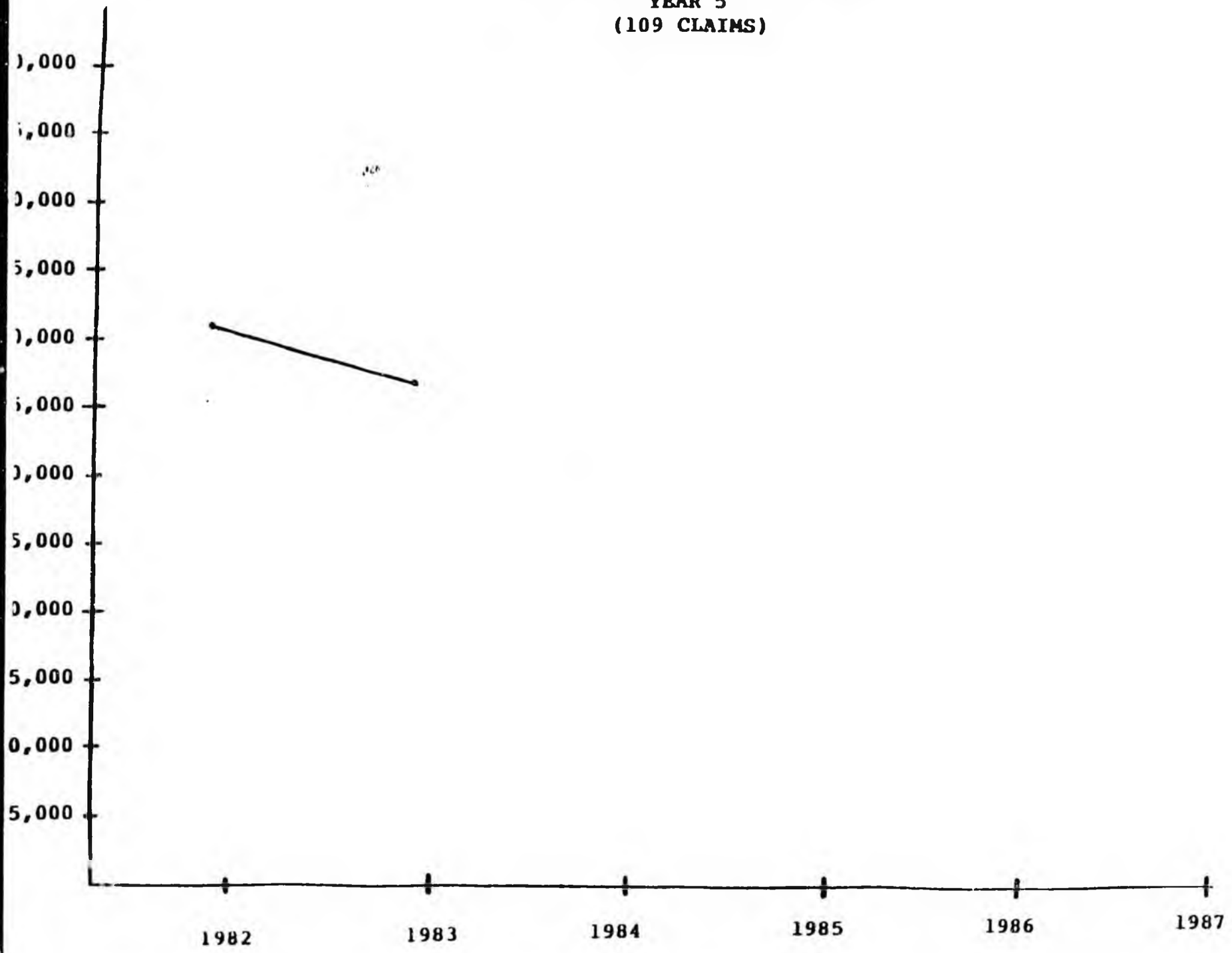
APPENDIX D-4

CLAIM SEVERITY AT
EQUAL LOSS DEVELOPMENT YEARS
YEAR 4
(263 CLAIMS)



APPENDIX D-5

CLAIM SEVERITY AT
EQUAL LOSS DEVELOPMENT YEARS
YEAR 5
(109 CLAIMS)



APPENDIX D-6

HB 350

MIEC

Medical Insurance Exchange of California
Medical Underwriters of California

May 10, 1989

MEMORANDUM TO ALASKA POLICYHOLDERS REGARDING RENEWAL RATES

(Policy Year August 1, 1989 to July 31, 1990)

This is to inform you that effective August 1, 1989, MIEC's basic rates for Alaska will be increased 11.7%. MIEC's recent loss experience in Alaska shows a continuing increase in the frequency and severity of claims, to the point where Alaska's claims now average almost twice the size, and about 35% greater frequency than for the company as a whole. Attached are graphs which compare Alaska's and MIEC's overall claims frequencies, severities and loss ratios for two recent five-year blocks of time.

In addition to this increase in basic rates, those doctors insured less than five years also will receive the step rate increases which occur as claims-made discounts diminish each year until the fifth, when the mature claims-made rate is attained. Some step-rate increases, and the 11.7% basic rate increase, will be modified by the following company-wide specialty classification changes:

- Cardiologists who do not perform catheterization or angioplasty by a 13% reduction. Rates of cardiologists who do perform these procedures will increase by 30.4%, in addition to the 11.7% basic rate increase. Cardiologists who conduct invasive procedures have incurred 90% of claims costs of all cardiologists MIEC insures. Over six years of combined claims experience, cardiology losses have been 39% higher than those of all non-surgical specialties. MIEC continues loss-prevention activities with this specialty through claims analysis, on-site visits, and office consultations.
- Family and general practitioners who do no surgery will receive a 10% rate reduction; those who do limited surgery and assist, a 14.3% reduction; and those who do surgery but no obstetrics, a 30.6% reduction.
- Physical medicine and rehabilitation specialists will receive a 10% rate reduction.
- Industrial medicine specialists will receive a 30.6% rate reduction.

The changes in classification result from MIEC's continuing analysis of loss patterns among specialties and MIEC's long-standing policy to adjust premiums to the relative losses of various specialties.

We are pleased to announce that because of reduced reinsurance costs, MIEC is able to lower the charges for limits of liability in excess of $1,000,000/$3,000,000 in many classifications. If you are interested in obtaining a quotation for either the $2,000,000/$4,000,000 or $5,000,000/$5,000,000 limits options, please call MIEC's Underwriting Department.

MIEC has been insuring Alaska physicians since 1978, and is Alaska's only doctor-owned, medical society-sponsored carrier. Physician ownership means physician direction of policy, physician peer review, active loss prevention, policy control over claims and underwriting, equitable treatment of policyholders, proper investigation, and vigorous, steadfast defense of claims through knowledge and experience in medical professional liability. MIEC is rated A+ by A.M. Best Company, the insurance industry rating service.

MIEC supports Alaska State Medical Association's ongoing efforts to achieve more meaningful tort reform. California's Medical Injury Compensation Reform Act (MICRA), combined with MIEC's loss prevention activities, have moderated rate increases there. The tort reforms which have moderated malpractice claims are MICRA's changes to the collateral source rule, limits on noneconomic damages, periodic payments of awards, and limits on attorneys' contingency fees.

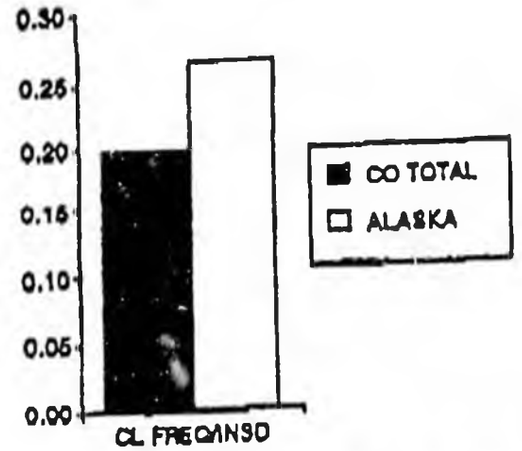
Upon approval of the new rates by the Alaska Insurance Division, premium invoices for renewal will be sent to policyholders in late June. If you have questions about these changes or wish to change your coverage limits or classification, please contact MIEC's Underwriting Department.

Sincerely,

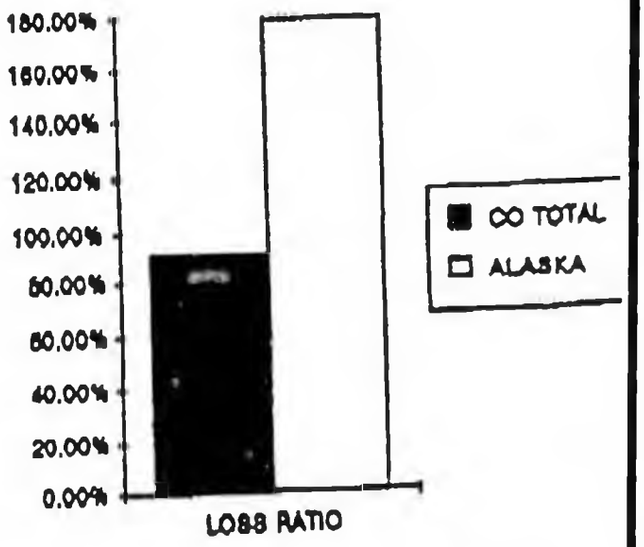
Board of Governors, Medical Insurance Exchange of California
Board of Directors, Medical Underwriters of California

MIEC

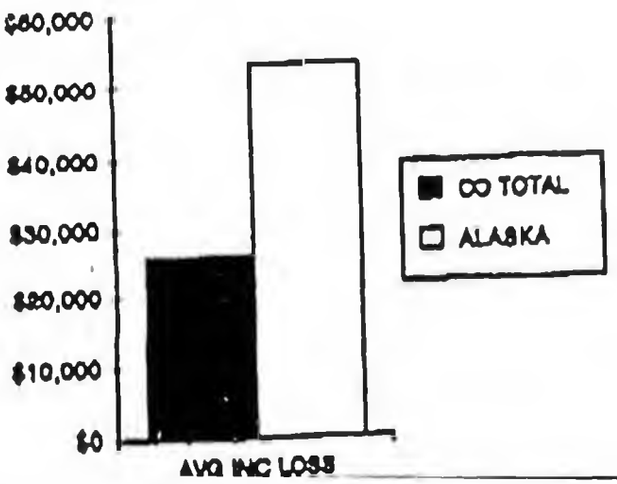
Medical Insurance Exchange of California
Medical Underwriters of California



1982/86 POLICY YEARS COMBINED
CLAIM FREQUENCY PER INSURED PER YEAR:
MIEC TOTAL AND ALASKA COMPARED



1982/86 POLICY YEARS COMBINED
LOSS RATIOS: MIEC TOTAL
AND ALASKA COMPARED



HB 350

MICA Medical Indemnity Corporation of Alaska

ALEUT PLAZA
4000 OLD SEWARD HWY., SUITE 203
ANCHORAGE, ALASKA 99503
(907) 563-3413

December 29, 1989

Representative Max Gruenberg
House Labor and Commerce Committee
House of Representatives
P.O. Box V
Juneau, AK 99811

Dear Representative Gruenberg:

The House Labor and Commerce Committee had hearings on November 30, 1989 at which time I was asked to have an "informal" chat with the committee. Since I wasn't prepared to testify, I gave you some estimated premium figures and promised to follow up with exact rate information.

MICA's 1990 Premium Schedule is enclosed for your information. The committee had asked me questions at the hearings specifically relating to the cost of insurance to physicians delivering babies. I mentioned that the majority of our phsician policyholders have limits $500,000 per claim, $1,000,000 aggregate. Physicians delivering babies are Class 3 on the schedule. Assuming a physician had policy limits of $500,000/1,000,000 and had been insured with MICA for five or more years his premium for 1990 would be $30,162. (This is about $20,000 less than I quoted to you.)

Another question is the difference in premium between a Family Practioner doing obstetries and those who were not. Assuming the same scenerio as above and that the Family Practioner not doing obstetrics was doing minor surgery the difference would be $14,046. In other words, the Family Practioner who delivers babies pay $14,046 to do so (or about 1/2 of the total premium is for obstetrical coverage).

I hope that this letter and the attached premium schedule better answers your questions. If you have any further questions, please feel free to call me.

Sincerely,

Mary A. Pierce
Executive Director

MAP/blb

Enclosure

MICA

Medical Indemnity
Corporation of Alaska

ALEUT PLAZA OFFICE BUILDING
4000 OLD SEWARD HIGHWAY, SUITE 203
ANCHORAGE, ALASKA 99503
TELEPHONE (907) 563-3414

1990

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

PROFESSIONAL LIABILITY COVERAGES

Explanation of Policy:

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

MICA's premium rates are derived from the historical pattern of reported claims resulting from the performance of professional services which form a "stair step" with an increasing number of claims being reported each year until the fifth year. In the first year, only about 19 % of the total claims resulting from professional services are reported; the second 39 %; the third 78 %; the fourth 93 %; the fifth and subsequent years, about 100 %.

Cost:

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

All policies issued by MICA are renewed on January 1 of each year. Your first years and renewal rates are pro-rated from the first date of coverage (inception date) of the original policy. For example, if your continuous coverage became effective on July 1, 1986, your annual renewal premium on January 1, 1990 would be pro-rated from January 1 through June 30 on the fourth year rates and from July 1 through December 31 on the fifth year rates.

Limits of Liability:

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

$200,000 per occurrence/$600,000 aggregate per calendar year.
$500,000 per occurrence/$1,000,000 aggregate per calendar year.
$1,000,000 per occurrence/$2,000,000 aggregate per calendar year.
$1,000,000 per occurrence/$3,000,000 aggregate per calendar year.

Reporting Endorsement (Tail Coverage) *

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

"Tail" coverage must also be recognized when a physician reduces rating classification to offset reduced premium charges while subsequently reported claims from the higher specialty continues to occur. This is currently being accomplishedby charging "tail" premium on a pro-rata basis as between the two speciality classes when the policy is ultimately terminated.

Cost:

The cost of "tail" coverage will depend upon the length of time you have been insured with MICA, limits of liability purchased, physician's rating class and will be subject to the company's rules, rates, and rating plans in effect at the time the Unlimited Reporting Endorsement is requested.

* The policy limits purchased for the Unlimited Reporting endorsement will be applicable just as if the policy had not been cancelled or terminated and all subsequently reported claims had been reported during the last policy year.

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

Retirement Benefit:

An Unlimited Reporting Endorsement (tail coverage) will be issued at no extra cost to any physician who has attained the age and years in the MICA program (as per the schedule below) and having completed five consecutive years as a MICA insured just prior to retirement:**

Age	Years as MICA Insured
60	5
59	6
58	7
57	8
56	9
55	10

**** Retirement is defined as totally ceasing the private practice of medicine. A limited or parttime practice is not considered retirement.**

Death or Total and Permanent Disability:

A Reporting Endorsement (tail coverage) will be issued at no extra cost because of death or permanent total disability, i.e., unable to continue the practice of medicine in any limited or modified capacity.

New Doctor Rule:

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

Claims Free Premium Discount:

A 20 % premium discount will be provided to our insured physicians for a five year claims free history. This policyholder benefit will be provided upon renewal following the completion of the fifth year in which a claims free record has been demonstrated.

Claims Experience Premium Surcharges:

Claims experience premium surcharges may be imposed upon insureds with two or more claims in the last three years in which some elements of negligence or other contributing adverse factors are involved.

Employee Coverages:

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

Employee premium charges are limited to: (1) Advanced Nurse Practitioners or Physician's Assistants added to a physician's or clinic's policy subject to 50 % of Class 1 premium (shares policy limits with employer, sponsor or supervising physician); (2) Physician's Assistants or Nurse Practitioners on policies providing separate limits of liability from sponsoring/supervising physician, subject to higher premium based upon specialty and practice situation; (3) employed Nurse Midwives or directly supervised Certified Registered Nurse Anesthetists (CRNAs) are subject to 100 % Class 3 annual premium; (4) unsupervised CRNAs or Nurse Midwives are subject to 100 % of Class 4 and Class 4A premium respectively.

No additional premium charges are incurred for other employees.

Locum Tenens:

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

This coverage is limited to 6 separate periods per year (except for illness or family emergencies of the insured physician) and any additional periods will involve the customary premium charges for short-term practice situations (see next paragraph)

A negative factor in considering the acceptability of a locum tenens physician is the lack of current or recent professional liability insurance coverage on the applicant. This lack precludes verification of prior claims experience and other elements of insurability.

Short Term Practice Situations:

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

Part Time Practitioners:

Class 0, 1, 1-A, 2, 2-A and Family practitioners in any class: 35 % of the scheduled annual premiums for 10 hours or less per week practice; 65 % of the scheduled annual premium for 20 hours or less per week practice.

Comprehensive General Liability Coverages:

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

This coverage is limited to premises actually occupied by our insured in rendering professional services. For example, if an insured occupied one suite of a building, coverage would be limited to only that suite. An entire building cannot be covered under the Comprehensive General Liability Endorsement unless the insured or the insured's employees occupy the entire building in the rendering of medical services.

Corporate/Partnership/Group Professional Liability:

This optional coverage is available at no additional charge to solo practitioners and group practices, providing each member or employed physician carries coverage through the Company. The only requirement for group limits is that the limits of liability on the group may never be higher than the lowest limit carried by any member of the group. The separate limits of liability for the corporation/partnership/group does not apply to policyholders who are solo practitioners nor does it apply concurrently or on an excess basis to the physician (s) scheduled on the policy or associated with the same medical organization who also allegedly provide neligent patient care for the same occurrence.

This form provides individual limits of liability to each physician named on the policy schedule except these limits shall not be concurrent nor excess to the corporate limits of liability stated in the previous paragraph.

Optional Shared Limits Professional Liability Group Coverage:

This optional coverage is available through the Company for your group at reduced premium levels. (see discount schedule that follows). One master policy is issued with each associated or employed physician covered by endorsement.

Coverages are limited to the course and scope of employment or association with your group. The **combined clinic/group insureds are subject to the single limits of liability per occurrence and annual aggregate limits as procured.**

Completion of the Physician's and Surgeon's Professional Liability Group Application is required, along with completion of individual application for each physician to be insured.

Discounts Per Limits of Liability

# Doctors on Policy	$500,000	$1,000,000
1	0	0
2	9%	7%
3	11%	9%
4	12%	10%
5	13%	11%
6	14%	12%
7	15%	13%
8	16%	14%
9+	17%	15%

Installments - Deferred Payments:

Initial policy issuance subject to deposit of $1,000 or two month's annual premium. Deferred payments are available in quarterly or semi-annual installments payable: 35%, 25 %, 25 % and 15 % quarterly or 60 % and 40 % semi-annually. Premium invoices should be paid upon receipt and the policy is subject to immediate cancellation if payment is not received by the first day of the quarter in which the premium is earned. Carrying charges are computed at 10 % annual simple interest on the unpaid balance.

The full premium for an Unlimited Reporting Endorsement must be received by the company within twelve months following its inception date. The Unlimited Reporting Endorsement will be cancelled at the end of this twelve month perio ' if the full premium has not been received at that time, and only premium earned for this twelve month Reporting Endorsement period will be charged in accordance with rates actuarially determined and filed with the Division of Insurance.

PHYSICIAN'S RATE CLASSIFICATIONS

Class 0
Psychiatry - Excluding ECT
Pathology

Class 1
Neurology
Physicians - no surgery
Applies to general practitioners and physician specialists who do not perform obstetrical procedures or major / minor surgery (other than incision of boils and superficial abscesses, suturing of skin and superficial fascia or neonate circumcision) who do not ordinarily assist in major surgical procedures.

Class 1-A
General Practitioners assisting at surgery (own patients only)
Opthalmology (excluding Radial Karatotomy)

Class 2
Physicians - minor surgery or assisting in major surgery*
Applies to general practitioners and physician specialists who perform minor surgery or assist in major surgery.
Neonatology
Cardiology

Class 2-A
Emergency Medicine
Therapeutic Radiology

Class 2-C
Urology

Class 3
Physicians - major surgery *
Physicians who include obstetrical procedures as any part of their practice.
Proctology
Otorhinolaryngology
Abdominal Surgery
General Surgery
Pediatric Surgery
Thoracic Surgery
Traumatic Surgery
Plastic and Reconstructrive Surgery (excluding cosmetic surgery)
Urology
Gynecology (No Obstetrics)

Class 4
Anesthesiology

Class 4-A
Physicians - major surgery *
Obstetrics - Gynecology
Cardiovascular Surgery
Hand Surgery
Plastic and Reconstructive Surgery (including cosmetic surgery)
Vascular Surgery
Orthopedic Surgery (excluding total joint procedures spinal surgery and insertion of prosthetic devices)

Class 5
Physicians - major surgery*
Neurosurgery
Orthopedic Surgery (including total joint procedures, spinal surgery and insertion of prosthetic devices)

***Major Surgery** -involves operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis, or any other operation that presents a distinct hazard to life becasue of the condition of a patient or the length or circumstances of an operation. It also includes removal of tumors (except skin tumors), open bone fractures, amputations, abortions, removal of any gland or organ, plastic surgery and any operations using general anesthesia.

NOTE: IF A PORTION OF THE PHYSICIANS PRACTICE IS IN A SPECIALITY WITH A HIGHER CLASS THAN HIS NORMAL SPECIALTY, HE OR SHE MAY BE PLACED IN THE HIGHER SPECIALTY FOR RATING PURPOSES.

CLAIMS - MADE PREMIUM SCHEDULE

Effective January 1, 1990

LIMITS OF LIABILITY: EACH CLAIM AND ANNUAL AGGREGATE

	1st - 5th Years	$200,000/$600,000	$500,000/$1,000,000	$1,000,000/$2,000,000 $1,000,000/$3,000,000 *
CLASS 0				
1st year rates	Jan. 1, 1990	2,924	3,192	3,601
• 2nd year renewal rates	Jan. 1, 1989	3,467	4,026	4,857
• 3rd year renewal rates	Jan. 1, 1988	4,559	5,607	7,119
• 4th year renewal rates	Jan. 1, 1987	5,026	6,271	8,058
• 5th year renewal rates	Jan. 1, 1986	5,177	6,485	8,361
CLASS 1				
1st year rates	Jan. 1, 1990	3,798	4,305	5,067
• 2nd year renewal rates	Jan. 1, 1989	4,828	5,809	7,230
• 3rd year renewal rates	Jan. 1, 1988	6,724	8,497	11,031
• 4th year renewal rates	Jan. 1, 1987	7,517	9,612	12,599
• 5th year renewal rates	Jan. 1, 1986	7,772	9,970	13,103
CLASS 1-A				
1st year rates	Jan. 1, 1990	4,548	5,270	6,326
• 2nd year renewal rates	Jan. 1, 1989	5,997	7,341	9,268
• 3rd year renewal rates	Jan. 1, 1988	8,584	10,980	14,391
• 4th year renewal rates	Jan. 1, 1987	9,657	12,482	16,499
• 5th year renewal rates	Jan. 1, 1986	10,001	12,964	17,176
CLASS 2				
1st year rates	Jan. 1, 1990	5,33.	6,286	7,651
• 2nd year renewal rates	Jan. 1, 1989	7,228	8,953	11,414
• 3rd year renewal rates	Jan. 1, 1988	10,542	13,593	17,928
• 4th year renewal rates	Jan. 1, 1987	11,909	15,503	20,605
• 5th year renewal rates	Jan. 1, 1986	12,348	16,116	21,464
CLASS 2-A				
1st year rates	Jan. 1, 1990	7,098	8,550	10,605
• 2nd year renewal rates	Jan. 1, 1989	9,971	12,547	16,196
• 3rd year renewal rates	Jan. 1, 1988	14,905	19,417	25,811
• 4th year renewal rates	Jan. 1, 1987	16,928	22,235	29,755
• 5th year renewal rates	Jan. 1, 1986	17,577	23,139	31,020

* PREMIUM COST IS 4% ABOVE $1,000,000/$2,000,000. LIMITS.

Claims-made premium prepared by Milliman & Robertson, Inc., consulting Actuaries for the Medical Indemnity Corporation of Alaska, are based on a five year pricing step for reported claims adjusted annually for claims experience.

•Retroactive dates and renewal premium apply to 2nd through 5th year annual renewal. First year physicians are subject to first year rates.

•All policies are renewed each year on January 1. All 1st and renewal premiums are pro-rated subject to the first day of coverage under the original policy.

CLAIMS - MADE PREMIUM SCHEDULE

Effective January 1, 1990

LIMITS OF LIABILITY: EACH CLAIM AND ANNUAL AGGREGATE

	1st - 5th Years	$200,000/$600,000	$500,000/$1,000,000	$1,000,000/$2,000,000 $1,000,000/$3,000,000 *
CLASS 2-C				
1st year rates	Jan. 1, 1990	8,294	10,089	12,613
• 2nd year renewal rates	Jan. 1, 1989	11,836	14,991	19,448
• 3rd year renewal rates	Jan. 1, 1988	17,872	23,377	31,171
• 4th year renewal rates	Jan. 1, 1987	20,342	26,813	35,976
• 5th year renewal rates	Jan. 1, 1986	21,133	27,915	37,518
CLASS 3				
1st year rates	Jan. 1, 1990	8,857	10,813	13,558
• 2nd year renewal rates	Jan. 1, 1989	12,713	16,140	20,978
• 3rd year renewal rates	Jan. 1, 1988	19,268	25,241	33,693
• 4th year renewal rates	Jan. 1, 1987	21,948	28,967	38,904
• 5th year renewal rates	Jan. 1, 1986	22,807	30,162	40,576
CLASS 4				
1st year rates	Jan. 1, 1990	11,218	13,850	17,520
• 2nd year renewal rates	Jan. 1, 1989	16,392	20,960	27,392
• 3rd year renewal rates	Jan. 1, 1988	25,120	33,052	44,266
• 4th year renewal rates	Jan. 1, 1987	28,680	37,997	51,176
• 5th year renewal rates	Jan. 1, 1986	29,821	39,582	53,393
CLASS 4-A				
1st year rates	Jan. 1, 1990	14,140	17,608	22,422
• 2nd year renewal rates	Jan. 1, 1989	20,944	26,926	35,330
• 3rd year renewal rates	Jan. 1, 1988	32,362	42,720	57,351
• 4th year renewal rates	Jan. 1, 1987	37,012	49,172	66,365
• 5th year renewal rates	Jan. 1, 1986	38,502	51,241	69,255
CLASS 5				
1st year rates	Jan. 1, 1990	19,199	24,116	30,914
• 2nd year renewal rates	Jan. 1, 1989	28,829	37,257	49,079
• 3rd year renewal rates	Jan. 1, 1988	44,906	59,463	80,014
• 4th year renewal rates	Jan. 1, 1987	51,443	68,528	92,670
• 5th year renewal rates	Jan. 1, 1986	53,536	71,433	96,729

* PREMIUM COST IS 4% ABOVE $1,000,000 /$2,000,000 LIMITS.

Claims-made premium prepared by Milliman & Robertson, Inc., consulting Actuaries for the Medical Indemnity Corporation of Alaska, are based on a five year pricing step for reported claims adjusted annually for claims experience.

•Retroactive dates and renewal premium apply to 2nd through 5th year annual renewal. First year physicians are subject to first year rates.

• All policies are renewed each year on January 1. All 1st and renewal premiums are pro-rated subject to the first day of coverage under the original policy