

HB

350

6-1380E
Ford
2/27/90

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

1 IN THE HOUSE

BY THE LABOR & COMMERCE COMMITTEE

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

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 SIXTEENTH LEGISLATURE - SECOND SESSION

5 A BILL

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

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

10 * Section 1. SHORT TITLE. This Act may be known as the Alaska Child-
11 birth Care Incentive Act.

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

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

17 (2) due to the cost of medical malpractice insurance some physi-
18 cians have chosen to become uninsured, which exposes the physician and
19 patients to unreasonable risk, forces some physicians to cease their med-
20 ical practice, and also acts as a general disincentive to practicing medi-
21 cine in the state;

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

25 (4) in rural areas of the state the high cost of medical mal-
26 practice insurance poses a serious threat to public health and safety.

27 (b) It is the purpose of this Act to provide immediate and substan-
28 tial relief to physicians by making adequate malpractice insurance avail-
29 able, while the legislature continues to develop legislation intended to

1 reduce the cost of medical malpractice insurance.

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

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

6 (1) to provide surplus in respect to policyholders that
7 [WHICH] may not exceed a total of \$3,000,000 outstanding at any time;
8 these obligations shall be subordinated to all other obligations of
9 the corporation; loans made under this paragraph shall be repaid to
10 the fund in annual installments of at least 25 percent of the excess
11 of premiums earned over the total of claims, reserves, expenses, and
12 assessments made by the association, if any; interest may not be
13 charged [SHALL BE PAID] on the outstanding balance [AT A RATE EQUAL TO
14 SEVEN PER CENT A YEAR];

15 if the director determines that the corporation is
16 unable to procure reinsurance from a private casualty insurer or
17 reinsurer for any liability incurred by contracts issued by it, addi-
18 tional loans up to an aggregate of \$6,000,000 when taken together with
19 loans made under (1) of this subsection to compensate for fluctuations
20 in loss experience; loans made under this paragraph shall be in parity
21 with all other obligations of the corporation except that they shall
22 be subordinated to obligations of policyholders and claimants for
23 indemnity of loss; these loans shall be repaid within five years;
24 interest may not be charged on the outstanding balance [AT AN ANNUAL
25 INTEREST RATE OF SIX PER CENT].

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

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

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

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

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

13 (1) 10 percent, if the physician practices in an urban
14 area;

15 (2) 50 percent, if the physician practices in a rural area
16 and acts as the attending physician in 20 or more births a year;

17 (3) 100 percent, if the physician practices in a rural area
18 and acts as the attending physician in at least one but fewer than 20
19 births a year, or provides prenatal care to at least one but fewer
20 than 20 patients a year.

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

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

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

1 or operation of the fund.

2 (g) In this section,

3 (1) "hospital" has the meaning given in AS 18.20.210;

4 (2) "physician" means a person licensed to practice medi-
5 cine under AS 08.64;

6 (3) "rural area" means an area located 60 or more miles
7 from a hospital;

8 (4) "urban area" means an area located less than 60 miles
9 from a hospital.

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

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

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26 malpractice insurance poses a serious threat to public health and safety.

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11 of premiums earned over the total of claims, reserves, expenses, and
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13 charged [SHALL BE PAID] on the outstanding balance [AT A RATE EQUAL TO
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15 (2) if the director determines that the corporation is
16 unable to procure reinsurance from a private casualty insurer or
17 reinsurer for any liability incurred by contracts issued by it, addi-
18 tional loans up to an aggregate of \$6,000,000 when taken together with
19 loans made under (1) of this subsection to compensate for fluctuations
20 in loss experience; loans made under this paragraph shall be in parity
21 with all other obligations of the corporation except that they shall
22 be subordinated to obligations of policyholders and claimants for
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6 to pay the cost of administering the fund.

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

13 (1) 25 percent, if the physician practices in an urban
14 community;

15 (2) 50 percent, if the physician practices in a rural
16 community and acts as the attending physician in 20 or more births a
17 year;

18 (3) 100 percent, if the physician practices in a rural
19 community and acts as the attending physician in at least one but
20 fewer than 20 births a year, or provides prenatal care to at least one
21 but fewer than 20 patients a year.

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24 amount the physician receives shall be prorated under guidelines
25 established by the corporation. The corporation may not pay an insur-
26 ance surcharge imposed on a physician's medical malpractice insurance.

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

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

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

3 (g) In this section,

4 (1) "physician" means a person licensed to practice medi-
5 cine under AS 08.64;

6 (2) "rural community" means a community with less than
7 5,000 permanent residents and less than 10,000 permanent residents
8 within a radius of 20 miles from the U.S. Post Office nearest to the
9 center of the community;

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

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

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

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

Alaska State Legislature

Legislative Research Agency



P.O. Box Y
Juneau, AK 99811-3100
Phone: (907) 465-3991
Fax: (907) 463-3351

November 15, 1989

MEMORANDUM

TO: Representative Dave Donley

ATTN: Ginger Baim

FROM: Patricia Young ^{py}
Legislative Analyst

RE: Medical Malpractice Insurance Premiums
Research Request 90.124

You asked this agency to ascertain whether any states have passed or are considering legislation which would prohibit insurers from classifying physicians into more than four groups for the purposes of determining medical malpractice liability premiums. You also wished to know the number of classifications used by insurers for Alaska physicians; the average cost of liability insurance for each class of physicians; and the estimated average cost if classifications were limited to four.

In addition, you asked if any states besides Arizona have adopted or are considering legislation which would create a matching fund to pay a portion of the cost of medical malpractice liability insurance premiums for physicians. You also wished to know how such laws are structured, i.e., whether assistance is limited to certain physician specialties, and whether assistance is based on a "sliding scale" of need or on a flat amount.

Limiting Classifications of Physicians

The limiting of classifications of physicians has been suggested by the National Insurance Consumer Organization (NICO) as a way of spreading the cost of malpractice insurance across a broader base of payees. This is one of several changes suggested by Robert Hunter, NICO president. (See Attachment A, "How to Solve the Medical Malpractice Crisis.") Neither Bob Boerner, of the National Council of State Legislatures (NCSL), nor Carol Brierly Golin, editor of the *Medical Liability Monitor*, which tracks state legislation in this area, are aware of any states which have enacted or are considering such legislation.

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Page 2

The Medical Indemnity Corporation of Alaska (MICA), which insures approximately 50 percent of Alaska's physicians, groups them into seven classes. As you will observe from MICA's current coverage and premium schedules (Attachment B), various factors determine cost. Averaging the cost of liability insurance per classification is possible; however, according to Art Stanford, MICA underwriting manager, such averaging will not reflect the actual experience of Alaska physicians. Mr. Stanford estimates that, by far, the greatest number of physicians are in the lower classifications, and he is unable to estimate the effect of limiting classifications.

The Medical Insurance Exchange of California (MIEC) insures the next greatest percentage of Alaska's physicians, with approximately 21 percent. This company groups physicians into ten classes. A copy of MIEC's current coverages and premiums schedules is Attachment C. According to Barbara Barnett, assistant underwriting manager, averaging actual premiums paid for each class would not be meaningful; averaging the cost per physician if classes were limited to four would likewise not produce meaningful information.

Such a change would result in less variation in premiums and would spread the cost of malpractice insurance across a broader base of payees; however, both Mr. Stanford and Ms. Barnett noted that a large number of physicians in low risk practice would be dissatisfied at subsidizing those in high risk practice, and they questioned the efficacy of the state's limiting classes with such a relatively small pool of physicians.¹ Ms. Barnett also commented that such legislation could adversely affect insurance availability because carriers might leave the state.

Obstetrical Care Incentive Programs

According to Ms. Golin, Hawaii, Arizona, and North Carolina have established funds to assist certain physicians with liability insurance premiums. Programs vary, but in each case the emphasis is on assistance for physicians who perform obstetrical services. A related program has also been initiated at the municipal level in Montgomery County, Maryland.

Hawaii was the first state to provide assistance of this kind. According to Becky Kendall, assistant executive director of the Hawaii Medical Association, the state legislature in 1986 appropriated \$125-\$150,000 to subsidize those physicians in rural areas who perform obstetrical services. Applying physicians must submit copies of their insurance premiums, information on the number of Medicaid cases handled, and verification of the annual number of deliveries performed. Ms. Kendall noted that the requirements are "quite informal." No specific percentage of indigent care is necessary for

¹Although 905 physicians hold active licenses in the state, fewer may be practicing.

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Page 3

qualification, and no financial need must be demonstrated on the part of the physicians. The major criteria for qualification is that a physician practice in a rural area. The fund is used to subsidize the difference between premiums which include obstetrical care coverage and premiums without such coverage, for gynecologists and general practitioners. The maximum subsidy per physician is \$30,000. Despite the informal nature of the requirements, only seven physicians are currently receiving this assistance.

Arizona has recently passed legislation to appropriate \$195,000 from the state general fund to be used for financial assistance to physicians who provide obstetrical services in rural areas identified as obstetrically underserved. Family physicians who perform fewer than 50 deliveries per year are eligible to receive up to \$5,000 per year; family physicians who perform more than 50 deliveries per year are eligible to receive up to \$10,000 per year; obstetricians are also eligible to receive up to \$10,000 per year.

North Carolina last year appropriated \$240,000 to provide assistance to obstetricians and family practice physicians who provide prenatal and obstetrical services in areas of the state that are underserved in this regard. Regulations require that qualifying physicians may not refuse care to patients based on their ability to pay. According to Bob Burns, assistant director of government affairs, North Carolina State Medical Society, the fund subsidizes the difference between premiums with obstetrical care coverage and premiums without such coverage, with a maximum subsidy of \$6,500 per physician. Funding has been continued at the same level for the current year. Mr. Burns noted that because the state has one of the highest infant mortality rates in the nation, proponents of this program are urging the legislature to increase the appropriation so that more physicians can participate.

In Montgomery County, Maryland, obstetricians are considered part-time county employees and are covered by the county's liability insurance when treating patients referred by the county. Physicians are covered by their own insurance when treating private patients. This program helps assure access to care for the medically indigent--patients who are frequently more high risk due to lack of prenatal care. According to Ken Heland, associate director of the American College of Obstetricians and Gynecologists and head of the Department of Professional Liability, in Maryland, insurance premiums are based partially on the number of deliveries physicians perform. Premiums for private practice have dropped because deliveries performed for county patients are not counted in liability calculations.

Copies of the Arizona and North Carolina bills are included in Attachment D. I hope you find this information useful.

Attachments

ATTACHMENT A
"How to Solve the Medical Malpractice Crisis"

HOW TO SOLVE THE MEDICAL MALPRACTICE "CRISIS"



Illustrations by Richard Thompson

By J. Robert Hunter

SURPRISE: IN POINT OF FACT, THE MEDICAL MALpractice system in the United States is actually something of a bargain. According to the latest data from the National Association of Insurance Commissioners, 1987 premiums for medical practice totaled \$4.6 billion. This number may sound huge by itself, but remember that there were 240 million people living in the United States at that time. So for each of them, the total cost for the current malpractice system averaged \$19—not a ruinously high figure, most would concede, and one that compares well with the \$133 that the *average* American spends on tobacco products.

What has been dubbed as a medical malpractice "crisis" is *not* a consequence of out-of-control costs for the aggregate system, no matter how you look at it. Measured against the yardstick of total medical costs, the system still looks reasonable. Americans spent a whopping \$404 billion on health care in 1988; even if medical malpractice costs were capped at zero, the bill for the nation's health care would only decline by 1.2%. I dare say that if you had no system to compensate victims of malpractice, and someone offered to do it for you for a percentage this small, you'd probably grab it.

There's no need to lose any sleep worrying about the financial fate of the medical malpractice insurers. According to the U.S. General Accounting Office, "the medical malpractice line yielded a profit of \$2.2 billion over the eleven-year period 1975 through 1985. . . . As a percentage of premiums earned, the medical malpractice line's cumulative rate of return . . . was a positive 15.3 percent when the reserves were discounted" (U.S. Government Accounting Office report, "Insurance: Profitability of the Medical Malpractice and General Liability Lines," June 13, 1987).

Since medical malpractice insurers write about \$2 of premium for each \$1 of net worth, insurers made about 30% on equity during this eleven-year period—an impressively lofty rate of return.

Since 1985, rates of return for medical malpractice insurers have risen by 10% over the eleven-year average cited by GAO.

Here's another, rather telling, fact about the medical malpractice insurance business. Between 1977 and 1987, U.S. medical malpractice insurers took in more than five times as much in premiums as they paid out in claims, according to A.M. Best's. Then, too, when insurance companies say that they had an "underwriting loss," that does not mean that they actually paid out more than they took in. Rather, it means that they estimate that they will eventually pay out more than they took in. As a result, even when companies have an "underwriting loss," they almost always take in much more than they pay out.

Since 50% of malpractice claims are not paid until about eight years after the policy is written, the under-

J. Robert Hunter is president, National Insurance Consumer Organization, Alexandria, Virginia.

writing loss figure is particularly misleading for medical malpractice insurance. On the one hand, the insurance company invests and earns interest on the money it keeps, while on the other hand, it deducts the entire amount for accounting purposes in the first year. Comparing current-dollar income with future-dollar expenses is really quite misleading.

Costs Aren't Allocated Fairly

Although the total cost of medical malpractice insurance is relatively low—about 1% of total health care costs—that cost is poorly allocated. Doctors in high-risk specialties are the victims of this misallocation.

Further, it is the good doctors (the overwhelming majority) who subsidize the bad doctors. Although study after study has shown that only a small percentage of doctors are responsible for a sizable percentage of malpractice, doctors who have never been sued pay the same premium as a doctor who's been found liable for malpractice several times.

Here's a sample of these data. In the Michigan "Report on the Liability Crisis" (1985), 19.3% of doctors were found to have accounted for 72.2% of all claims, whereas 58.1% had had no claims. Similarly, in a somewhat earlier study, the Florida Insurance Commissioner's "Closed Claims Study of Medical Malpractice Insurance, 1975-82," 0.7% of the doctors accounted for 24% of the claims; one doctor was the subject of thirty-one claims. S. Ferber and B. Sheridan reported, in "Six Cherished Malpractice Myths Put to Rest" that, in Los Angeles, 0.6% of the doctors accounted for 30% of all payments (*Medical Economics*, vol. 52, 1975, p. 150).

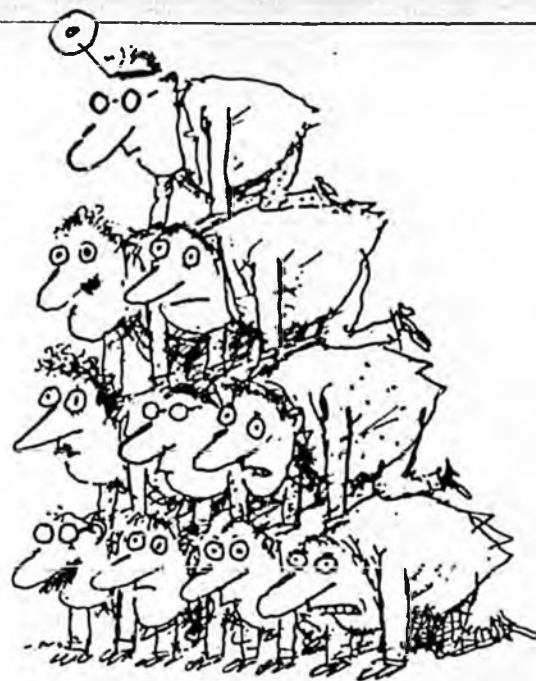
Unlike auto insurance, where accidents and tickets mean higher premiums, most medical malpractice insurance doesn't stipulate surcharges for physicians who have been successfully sued.

Finally, the doctors who perform few procedures subsidize those who do many procedures. Under the rating system now in use in most states, the rural general practitioner who delivers only a few babies every year can pay as much as an urban obstetrician/gynecologist who delivers hundreds of babies.

Insurance companies also tend to divide doctors into too many categories, with too few doctors in some. As a result, one big judgment against a doctor in a sparsely populated category can mean a huge increase in premiums for all of the doctors in that category. If the numbers of categories were reduced, and the numbers of doctors in each category increased, insurance premiums would decrease dramatically for the doctors in the high-risk specialties (at the same time, coverage costs for physicians in other categories would rise slightly).

If you can picture the various medical specialties arranged in a pyramid, with the relatively numerous general practitioners (GPs) at the bottom and the relatively few specialists at the top, the problem becomes easier to visualize.

When a person with a bad back goes to his or her GP,



the likelihood of a major malpractice suit arising from that visit is negligible. But if the back proves to be a serious medical problem, the patient will be referred up the specialty pyramid to the neurosurgeon. In Colorado, the leading insurer has only 233 of these among its 3,744 insureds.

It violates the insurance spread-of-risk principle to force so much through such a narrow base. (Even though neurosurgeons' net income, after medical malpractice premiums, is excellent—\$200,000 a year—according to *Medical Economics'* gross and net income reports.)

Why must the defense costs for the convoluted suits that neurosurgeons *win* be spread among only the neurosurgeons? Why shouldn't the referring physician and the hospital granting privileges bear some of the cost of successful suits (as incentives for safer referrals/privilege granting)?

Which brings another point to mind: Doctors, in many instances, are forced to pay for damages, when in fact it is the hospital that should pay. Today, when negligence occurs in a hospital (for instance, in connection with surgery or delivering babies), the insurer for the doctor doing the surgery or delivering the baby often must pay for the negligence. So the hospital, in many cases, lacks sufficient incentive to police the doctors who practice under its roof; the cost of high-risk care is therefore borne solely by a small group of doctors.

If procedures done in a doctor's office were charged to doctors, while procedures performed in hospitals were charged to hospitals, the cost of high-risk care would be spread over a large number of beds, hospitals would have more incentive to police doctors, and malpractice insurance premiums for most doctors would drop. Studies cited in a recent publication from Public Citizens Health Research Group ("Medical Malpractice: The Need for Disciplinary Reform, Not Tort Reform," August 1985) unanimously concluded that discipline for practicing physicians is woefully inadequate.

Excessive Rates?

Medical malpractice insurers—and particularly the doctor-owned insurers—have raised their rates, more than is actuarially justified, in response to “suggestions” from Lloyd’s of London and other reinsurers.

According to John Spinella, president of the physician-owned malpractice insurance company in Maryland, “in order to keep [Lloyd’s] participation on cover we had to agree to some strong suggestions from the reinsurer to beef up the rate charged to the OBs” (statement before the Governor’s Task Force on Medical Malpractice, October 22, 1985).



COPIC Insurance Company in Colorado was required by its reinsurer, North American Reinsurance Company, not to discount reserves or otherwise reflect investment income in setting prices, thereby driving up the premium charged to doctors dramatically, even though that action was in violation of Colorado ratemaking requirements.

In addition, requests for rate increases are often based on false assumptions. For example, the Maryland Mutual sought a 29% increase in 1985 based on the assumption that it would earn a 5% annual return on its investments (although it had traditionally earned, and was currently earning, more than 9%) and that inflation would be in excess of 10% (inflation at that time was well under 10%). If proper assumptions had been made, the insurance company would have needed a 10.5% *reduction* in its rates, rather than a 29% increase, to maintain its current rate of return.

Nor would tort reform, that ubiquitously mentioned *deus ex machina*, be of much help.

In testifying before the Maryland governor's task force, John Spinella admitted that “Even if every one of the Task Force's recommendations [on tort reform] were fully implemented, we doubt that there would be any discernible change and fear that problems would be exacerbated.” And a 1985 study for the U.S. Health Care Financing Administration analyzed the effect of caps on awards and

other limitations on malpractice suits enacted during the mid-1970s, and concluded that these “reforms” did not result in lower insurance premiums.

In Florida, St. Paul Fire and Marine Co. has undertaken closed-claim studies which, it says, show that the savings resulting from five major tort reforms proposed for that state (eliminating the collateral source rule, capping non-economic damages, restricting of joint and several liability, limiting punitive damages, and requiring periodic payment of future economic damages) would have “no effect.”

How to Lower Insurance Rates

1. Require insurance companies to experience-rate doctors.

Drivers who have been in several serious auto accidents pay more, while drivers who have never had an accident pay less. Yet doctors found liable for malpractice several times pay the same as doctors who have never been sued. This doesn't make sense; good doctors, like good drivers, should pay less, and doctors involved in malpractice, like drivers involved in accidents, should pay more. Also, doctors who do fewer procedures ought to pay less than those who do many.

2. Reduce the number of categories of doctors and increase the number of doctors in each category.

In this way, risks will be spread as widely as possible.

3. Charge any malpractice that occurs in doctors' offices to doctors, and malpractice that happens in hospitals to hospitals.

This allocation will serve to maximize hospitals' incentive to police staff physicians and spread risks more widely.

4. Tighten state regulation of malpractice insurance.

Insurance companies are *exempt* from antitrust laws, so price fixing is legal. In one southern jurisdiction, all five insurers charge the same rate. Insurer inefficiency results. The average malpractice writer in the nation spends 43% of the premium dollar on expenses; there are also more efficient writers who spend only 12% to 15% for expenses.

5. Penalize frivolous suits and defenses.

Plaintiffs' attorneys should be penalized for bringing suits that are not solidly based on potential negligence. Defense attorneys (who get paid by the hour, win or lose) have little incentive to expedite proceedings.

6. Limit lawyer fees.

Limiting fees, however, has to be done in a balanced way, so that both plaintiff and defense attorneys' fees are controlled at the same time.

7. Focus on peer review.

The best way to bring down malpractice premiums is to reduce the incidence of malpractice. Peer review is very poorly done in most states, because of fear of lawsuits for antitrust or slander, camaraderie among doctors, lack of funding, poor information, and so on. So this constitutes another prime area for reform of the medical malpractice system. □

ATTACHMENT B
Medical Indemnity Corporation of Alaska (MICA) 1989
Professional Liability Coverages and Premium Schedules

BOARD OF GOVERNORS:

William G. Brock, Chairman
David J. Frazier, 1st Vice-Chairman
Frederick R. Hood, M.D., 2nd Vice-Chairman
David S. Grauman, M.D., Member At Large
Ronald W. Keller, M.D.
Renee Murray
Kim C. Smith, M.D.
C. Keith Campbell
Patricia L. Miles

ADMINISTRATIVE SERVICES:

Mary Pierce, Executive Director
Janet Sloan Johnston, Claim Manager
Penny Chmielewski, Risk Management Coordinator
Art Stanford, Underwriting Manager
Vickie Powell, Policyholder Services

MICA Medical Indemnity
Corporation of Alaska
ALEUT PLAZA OFFICE BUILDING
4000 OLD SEWARD HIGHWAY, SUITE 203
ANCHORAGE, ALASKA 99503
TELEPHONE (907) 563-3414

1989

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

Death or Total and Permanent Disability:

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

New Doctor Rule:

For physicians entering private practice for the first time following completion of medical school, residency training, military 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 surcharges 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 customary premium charges.

Part Time Practitioners:

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

Short Term Practice Situations:

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

Comprehensive General Liability Coverages:

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

This coverage is limited to only those premises actually occupied by our insured in rendering professional services. For example, if an insured occupied only one suite of a building, coverage would be limited to only that suite and not the entire building and parking lots. 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. Limits of each physician's coverage must be equal to that carried by 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 provided negligent patient care for the same occurrence.

This form provides individual limits of liability to each physician named on the policy schedule in an amount equal to the limits of liability stated on the declarations page of the policy except these limits shall not be concurrent nor excess to the corporate limits of liability as 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%

PHYSICIAN'S RATE CLASSIFICATIONS

Class 1

Neurology

Psychiatry - excluding ECT;

Physicians - no surgery. Applies to general practitioners and physician specialists who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia) who do not ordinarily assist in surgical procedures.

Class 2

Neonatology

Ophthalmology (Excluding Radial Keratotomy)

Physicians - minor surgery or assisting in major surgery. *
Applies to general practitioners and physician specialists who perform minor surgery (including catheterization) or assist in major surgery.

Class 2-A

Emergency Medicine

Class 3

Physicians who include obstetrical procedures as any part of their practice. (May still be indicated as class 2-B on policy:)

Physicians - major surgery *

Proctology

Otorhinolaryngology

Abdominal Surgery

General Surgery

Pediatric Surgery

Thoracic Surgery

Traumatic Surgery

Plastic and Reconstructive Surgery, excluding cosmetic surgery

Urology

Gynecology (No Obstetrics)

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.

Class 4

Anesthesiology

Class 4-A

Physicians - major surgery

Therapeutic Radiology

Obstetrics - Gynecology

Cardiovascular Surgery

Hand Surgery

Plastic and Reconstructive Surgery, including cosmetic surgery

Vascular Surgery

Orthopedic Surgery, excluding total joint procedures, spinal surgery and insertion of prosthetic devices.

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 because 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 PHYSICIAN'S PRACTICE IS IN A SPECIALTY WITH A HIGHER CLASS THAN HIS NORMAL SPECIALTY, HE OR SHE WILL BE PLACED IN THE HIGHER SPECIALTY FOR RATING PURPOSES.

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 entitled CLAIMS-MADE PREMIUM SCHEDULE.

All policies issued by MICA are renewed on January 1 of each year. Your first years and renewal rates are pro-rated from the first date of coverage (inception date) of the original policy. For example, if your continuous coverage became effective on July 1, 1985, your annual renewal premium on January 1, 1989 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.

Tail Coverages:

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 accomplished on a pro-rata basis when the policy is ultimately terminated, but depends on the company's rules, rates and rating plans in effect at the time the physician's class reduction is made.

Cost:

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

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

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.

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

* The policy limits in effect at the time the Unlimited Reporting Endorsement is purchased will be applicable just as if the policy had not been cancelled or terminated and the claim had been reported during the last policy year.

CLAIMS - MADE PREMIUM SCHEDULE

Effective January 1, 1989 **

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 1				
1st year rates	Jan. 1, 1989	3,087	3,598	4,364
• 2nd year renewal rates	Jan. 1, 1988	4,532	5,644	7,269
• 3rd year renewal rates	Jan. 1, 1987	7,141	9,275	12,374
• 4th year renewal rates	Jan. 1, 1986	8,027	10,504	14,098
• 5th year renewal rates	Jan. 1, 1985	8,082	10,581	14,306
CLASS 2				
1st year rates	Jan. 1, 1989	4,477	5,396	6,740
• 2nd year renewal rates	Jan. 1, 1988	7,031	8,950	11,736
• 3rd year renewal rates	Jan. 1, 1987	11,515	15,161	20,441
• 4th year renewal rates	Jan. 1, 1986	13,029	17,256	23,376
• 5th year renewal rates	Jan. 1, 1985	13,125	17,387	23,560
CLASS 2-A *				
1st year rates	Jan. 1, 1989	6,066	7,451	9,454
• 2nd year renewal rates	Jan. 1, 1988	9,886	12,728	16,840
• 3rd year renewal rates	Jan. 1, 1987	16,514	21,887	29,661
• 4th year renewal rates	Jan. 1, 1986	18,747	24,972	33,980
• 5th year renewal rates	Jan. 1, 1985	18,887	25,166	34,251
CLASS 2-B/3				
1st year rates	Jan. 1, 1989	7,655	9,506	12,168
• 2nd year renewal rates	Jan. 1, 1988	12,742	16,506	21,944
• 3rd year renewal rates	Jan. 1, 1987	21,514	28,613	38,880
• 4th year renewal rates	Jan. 1, 1986	24,465	32,688	44,584
• 5th year renewal rates	Jan. 1, 1985	24,650	32,944	44,942
CLASS 4				
1st year rates	Jan. 1, 1989	11,032	13,873	17,936
• 2nd year renewal rates	Jan. 1, 1988	18,810	24,535	32,790
• 3rd year renewal rates	Jan. 1, 1987	32,138	42,906	58,472
• 4th year renewal rates	Jan. 1, 1986	36,615	49,085	67,117
• 5th year renewal rates	Jan. 1, 1985	36,895	49,473	67,659
CLASS 4-A				
1st year rates	Jan. 1, 1989	12,422	15,671	20,311
• 2nd year renewal rates	Jan. 1, 1988	21,309	27,841	37,256
• 3rd year renewal rates	Jan. 1, 1987	36,512	48,791	66,539
• 4th year renewal rates	Jan. 1, 1986	41,617	55,837	76,395
• 5th year renewal rates	Jan. 1, 1985	41,938	56,279	77,013
CLASS 5				
1st year rates	Jan. 1, 1989	16,991	21,578	28,115
• 2nd year renewal rates	Jan. 1, 1988	29,519	38,703	51,931
• 3rd year renewal rates	Jan. 1, 1987	50,886	68,129	93,046
• 4th year renewal rates	Jan. 1, 1986	58,056	78,021	106,881
• 5th year renewal rates	Jan. 1, 1985	58,505	78,641	107,749

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

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

• RETROACTIVE DATES AND RENEWAL PREMIUMS APPLY TO 2ND THROUGH 5TH YEAR ANNUAL RENEWAL. 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.

** SUBJECT TO 12.6 % INCREASE (RETROACTIVE TO 1/1/89) IF MICA'S FEDERAL TAX LIABILITY HAS NOT BEEN LEGISLATIVELY RESOLVED BY 7/1/89.

ATTACHMENT C
Medical Insurance Exchange of California
(MIEC) 1989 Coverage Classification and Premium Schedule



1989 Coverage Classification and Premium Schedule

If you practice in more than one specialty, use the highest rated specialty.

Table with 2 columns: CLASS and SPECIALTY. Lists medical specialties and their corresponding class numbers.

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*Without ECT or drug shock therapy. With ECT or drug shock therapy, use Class 4

Partnership/Corporation Liability and Full Time Employed Physicians — 7% if all partners/shareholders and employed doctors have \$500,000/1,500,000 limits; 2.5% if all partners/shareholders and employed doctors have \$1,000,000/3,000,000 limits or higher.

Secretaries, Receptionists and Bookkeepers — No charge.

Optional Coverages:

Professional premises/limited non-owned automobile liability — Covers certain liabilities for injuries sustained by the public or for damage to property of third persons at your offices.

arising from an employee's use of an automobile (not owned, rented or leased to you) in the course of your professional practice, up to \$100,000 for bodily injury and \$25,000 for property damage.

LIMITS OF LIABILITY: Bodily injury, \$500,000 each claim/aggregate, or \$1,000,000 each claim/aggregate (to coincide with professional liability limits, but not higher than \$1,000,000); Property damage, \$100,000.

PREMIUM: No additional premium for premises occupied as physicians' professional offices. Clinics and other premises: refer to MIEC.

Defense coverage for miscellaneous liability

Provides up to \$100,000 legal defense coverage only for alleged acts or omissions involving:

- Certain civil actions or proceedings, including a physi-

cian's acts or omissions as an officer of a national, state or local medical or specialty society;

- Alleged wrongful termination or discrimination against an employee;
■ Breach of contract or other alleged misconduct in the nature of a commercial or fee dispute arising from professional practice;
■ Assault, battery, false arrest or personal restraint, malicious prosecution or conspiracy arising from professional practice.

This optional coverage is fully described in Part IV of the MIEC policy and is subject to the terms and conditions of the policy and endorsements actually issued. MIEC pays 90% of legal expenses to a maximum amount of \$100,000.

If you are interested in Part IV coverage, please contact MIEC for an application and premium quotation.

MEDICAL INSURANCE EXCHANGE OF CALIFORNIA

ALASKA

CLAIMS MADE PROFESSIONAL LIABILITY PREMIUM SCHEDULE

EFFECTIVE AUGUST 1, 1989

LIMITS OF LIABILITY: 500,000 EACH CLAIM / 1,500,000 ANNUAL AGGREGATE

DOCTORS COVERAGE CLASSIFICATIONS	FIRST YEAR RATES RETROACTIVE DATES: 01/01/89 OR LATER		SECOND YEAR RATES RETROACTIVE DATES: 01/01/88 - 12/31/88		THIRD YEAR RATES RETROACTIVE DATES: 01/01/87 - 12/31/87		FOURTH YEAR RATES RETROACTIVE DATES: 01/01/86 - 12/31/86		FIFTH YEAR RATES RETROACTIVE DATES: 08/01/75 - 12/31/85	
	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY
1. COVERAGE CLASS 1	2,124	531	4,172	1,043	5,304	1,326	5,728	1,432	6,220	1,555
2. COVERAGE CLASS 2	2,700	675	5,308	1,327	6,748	1,687	7,288	1,822	7,916	1,979
3. COVERAGE CLASS 3	3,472	868	6,824	1,706	8,676	2,169	9,368	2,342	10,176	2,544
4. COVERAGE CLASS 4	3,856	964	7,584	1,896	9,640	2,410	10,408	2,602	11,308	2,827
5. COVERAGE CLASS 5	4,436	1,109	8,720	2,180	11,084	2,771	11,972	2,993	13,004	3,251
6. COVERAGE CLASS 6	5,784	1,446	11,372	2,843	14,456	3,614	15,612	3,903	16,964	4,241
7. COVERAGE CLASS 7	9,640	2,410	18,952	4,738	24,092	6,023	26,020	6,505	28,268	7,067
8. COVERAGE CLASS 8	13,880	3,470	27,292	6,823	34,692	8,673	37,468	9,367	40,708	10,177
9. COVERAGE CLASS 9	19,276	4,819	37,904	9,476	48,184	12,046	52,040	13,010	56,536	14,134
10. COVERAGE CLASS 10	26,212	6,553	51,552	12,888	65,528	16,382	70,772	17,693	76,888	19,222
11. NURSE/TECHNICIAN	164	41	320	80	408	102	440	110	476	119
12. PHYSIOTHERAPIST	324	81	640	160	812	203	876	219	952	238
13. PHYS ASST/NURSE PRAC	388	97	760	190	964	241	1,044	261	1,132	283

ALASKA 500,000 / 1,500,000 LIMITS
 DATE PREPARED: MARCH 29, 1989
 PROCEDURE: NEWPREM
 USERID: KAREN8

MEDICAL INSURANCE EXCHANGE OF CALIFORNIA

ALASKA

CLAIMS MADE PROFESSIONAL LIABILITY PREMIUM SCHEDULE

EFFECTIVE AUGUST 1, 1989

LIMITS OF LIABILITY: 1,000,000 EACH CLAIM / 3,000,000 ANNUAL AGGREGATE

DOCTORS COVERAGE CLASSIFICATIONS	FIRST YEAR RATES RETROACTIVE DATES: 01/01/89 OR LATER		SECOND YEAR RATES RETROACTIVE DATES: 01/01/88 - 12/31/88		THIRD YEAR RATES RETROACTIVE DATES: 01/01/87 - 12/31/87		FOURTH YEAR RATES RETROACTIVE DATES: 01/01/86 - 12/31/86		FIFTH YEAR RATES RETROACTIVE DATES: 08/01/75 - 12/31/85	
	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY
1. COVERAGE CLASS 1	2,496	624	4,908	1,227	6,236	1,559	6,736	1,684	7,320	1,830
2. COVERAGE CLASS 2	3,176	794	6,244	1,561	7,940	1,985	8,572	2,143	9,316	2,329
3. COVERAGE CLASS 3	4,084	1,021	8,028	2,007	10,204	2,551	11,020	2,755	11,972	2,993
4. COVERAGE CLASS 4	4,536	1,134	8,920	2,230	11,340	2,835	12,244	3,061	13,304	3,326
5. COVERAGE CLASS 5	5,216	1,304	10,260	2,565	13,040	3,260	14,084	3,521	15,300	3,825
6. COVERAGE CLASS 6	6,804	1,701	13,380	3,345	17,008	4,252	18,368	4,592	19,956	4,989
7. COVERAGE CLASS 7	11,340	2,835	22,300	5,575	28,344	7,086	30,612	7,653	33,256	8,314
8. COVERAGE CLASS 8	16,328	4,082	32,108	8,027	40,816	10,204	44,080	11,020	47,888	11,972
9. COVERAGE CLASS 9	22,676	5,669	44,596	11,149	56,688	14,172	61,220	15,305	66,512	16,628
10. COVERAGE CLASS 10	30,840	7,710	60,648	15,162	77,092	19,273	83,260	20,815	90,456	22,614
11. NURSE/TECHNICIAN	192	48	376	94	476	119	516	129	560	140
12. PHYSIOTHERAPIST	384	96	752	188	956	239	1,032	258	1,120	280
13. PHYS ASST/NURSE PRAC	456	114	896	224	1,136	284	1,228	307	1,332	333

ALASKA 1,000,000/ 3,000,000 LIMITS
 DATE PREPARED: MARCH 29, 1989
 PROCEDURE: NEWPREM
 USERID: KARENB

ATTACHMENT D
Arizona and North Carolina Bills

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.

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

2 Section 1. Appropriation; purpose; exemption

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

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

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

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

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

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

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

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

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

1 2. Shall be a registered provider with the Arizona health care cost
2 containment system who has established a contract for obstetrical services
3 with at least one or more of the system's prepaid contractors.
4 3. The physician shall be licensed by the appropriate licensure
5 board.
6 D. Family physicians who perform less than fifty deliveries per
7 year and who are required to pay an additional premium to perform
8 obstetrical services shall be eligible to receive an amount not to exceed
9 five thousand dollars. Family physicians who perform more than fifty
10 deliveries per year and who are required to pay an additional premium to
11 perform obstetrical services shall be eligible to receive an amount not to
12 exceed ten thousand dollars. Obstetricians who are required to pay an
13 additional premium to provide obstetrical services shall be eligible to
14 receive an amount not to exceed ten thousand dollars. Payment of one-half
15 of the financial assistance identified in this section shall be contingent
16 upon receipt of the report required pursuant to subsection F of this
17 section. The second payment shall be paid upon receipt of the second
18 report required pursuant to subsection F of this section.
19 E. Physicians seeking financial assistance shall respond to the
20 department's notice within thirty days of receipt of such notice in a
21 format prescribed by the department. The department shall evaluate the
22 physician's request for financial assistance and shall classify the
23 requests according to the city or town's need for obstetrical services and
24 ability to meet all or at least one of the criteria specified in
25 subsection B of this section. The highest classification shall be
26 assigned to those cities or towns which meet all of the criteria specified
27 in subsection B of this section. The lowest classification shall be
28 assigned to those cities or towns which meet at least one of the criteria
29 specified in subsection B of this section. The department shall establish
30 contracts with those physicians whose requests are assigned the highest
31 classification. If funds remain available, the department shall proceed
32 in descending order to establish contracts with those physicians whose
33 requests have been assigned a lower classification until funding is
34 depleted.
35 F. The financial assistance awarded pursuant to subsection E of
36 this section shall be used for each physician who meets the qualifications
37 of subsection C of this section, is under contract with the department to
38 remain in practice in the rural area for the contract year and who
39 provides a report upon completion of one-half of the contract term and
40 upon conclusion of the contract to the department which identifies the
41 number of women to whom the physician has provided medical services during
42 delivery, the ages of the women, the number of prenatal visits each woman
43 received, the number of women who are at or below federal poverty
44 standard, the number of Arizona health care cost containment system
45 enrolled women served and the insurance status of the women. Contracts
46 pursuant to this section are exempt from the requirements of title 41,
47 chapter 23, Arizona Revised Statutes.

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

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

28 I. The appropriation made in this section is exempt from section
29 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

HEALTH, WELFARE, AGING AND ENVIRONMENT (Cont'd.)

organizations and their employees who distribute food to the public at no charge. Eliminates gross negligence and recklessness as grounds for civil action or criminal prosecution.

Multi-county - incorporation - cities - correction NOW: Rural physicians:
financial assistance (H.B. 2467) - Chapter 290

Appropriates \$195,000 from the state general fund to the department of health services (DHS) to provide financial assistance to rural allopathic and osteopathic physicians. The appropriation is exempt from lapsing.

Requires the Department of Health Services (DHS) to identify areas that are underserved with regard to obstetrical services and to identify licensed physicians in those areas who have current obstetrical delivery privileges at one or more rural, non-federal hospitals and who are AHCCCS registered providers.

The financial assistance is not to exceed \$5,000 for family physicians who perform less than 50 deliveries and who pay an additional insurance premium to perform obstetrical services and is not to exceed \$10,000 for both family physicians who perform more than 50 deliveries and obstetricians who pay an additional insurance premium to perform obstetrical services. The financial assistance shall be made in two payments during the year upon receipt of information reported by the physicians. Financial assistance shall be determined on the basis of the area's need for obstetrical services and meeting the criteria established for underserved areas.

Requires the University of Arizona College of Medicine to develop a plan to address the delivery of health care services in rural Arizona. The report shall be submitted to the Governor, President of the Senate and Speaker of the House of Representatives by February 1, 1990.

Requires the DHS to report to the Governor, President of the Senate and Speaker of the House of Representatives by February 1, 1990 on the status of the initial distribution of the financial assistance. The DHS shall report again by January 1, 1991, on the effectiveness of the program.

Contracts with qualifying physicians are exempt from the requirements of the state procurement code.

Joint legislative committee: health care (H.B. 2478) - Chapter 216

Establishes a 23-member joint legislative committee on health care to gather and compare statistical information concerning the inability of many Arizonans to obtain health care insurance. Requires the committee to develop a written report, to be submitted to the Governor, the President of the Senate and Speaker of the House of Representatives by December 31, 1989.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1987

H

D

HOUSE DRH7342-LK659

Short Title: Rural Obstetrical Care Incentive.

(Public)

Sponsors: Representatives Hunter, E. Warren, and Woodard.

Referred to:

1 A BILL TO BE ENTITLED
2 AN ACT TO APPROPRIATE FUNDS TO THE DEPARTMENT OF HUMAN
3 RESOURCES TO ESTABLISH A PROGRAM TO COMPENSATE FAMILY
4 PHYSICIANS AND OBSTETRICIANS WHO AGREE TO PROVIDE
5 PRENATAL AND OBSTETRICAL SERVICES IN COUNTIES THAT ARE
6 UNDERSERVED WITH REGARD TO THESE SERVICES.

7 Whereas, there are currently 22 counties in the State which have no
8 physicians to provide prenatal or obstetrical care in those counties, most of which are
9 rural counties; and

10 Whereas, there are 20 counties in the State in which more than half of
11 the expectant mothers must leave the county for obstetrical care because there are
12 not enough physicians in their home county to provide obstetrical care; and

13 Whereas, prior to 1985 nearly 500 family physicians in North Carolina
14 were providing obstetrical care; and

15 Whereas, after severe increases in liability insurance premiums, some in
16 excess of three hundred fifty percent (350%), the number of family physicians
17 providing obstetrical care has dropped to 189, and numerous obstetricians have
18 dropped that part of their practice; and

1 Whereas, it is in the interest of the State to provide quality prenatal and
2 neonatal care and to provide access to health care for all its citizens; Now, therefore,
3 The General Assembly of North Carolina enacts:

4 Section 1. From the funds appropriated from the General Fund to the
5 Department of Human Resources there is established a reserve of nine hundred fifty
6 thousand dollars (\$950,000) for the 1988-89 fiscal year to fund a new program to
7 compensate family physicians and obstetricians who agree to provide prenatal and
8 obstetrical services in counties that are underserved with regard to these services.
9 The Division of Health Services shall adopt rules determining the counties that are
10 underserved with respect to obstetrical care that are to be part of the program; the
11 scope of the obstetrical services that are to be provided by a physician for that
12 physician to be eligible to receive assistance under the program; and the amount and
13 nature of the assistance to be provided to eligible physicians. Specific rules issued by
14 the Division of Health Services governing this new program shall include:

- 15 (1) A physician who provides obstetrical care in a county that is
16 designated as being underserved for prenatal and obstetrical care
17 by the Division of Health Services will be compensated for either
18 the difference between his premiums with obstetrical care coverage
19 and his premiums without obstetrical care coverage, or six
20 thousand five hundred dollars (\$6,500), whichever is less;
- 21 (2) Physicians providing obstetrical care through an arrangement with
22 their local health department shall have the option of providing
23 the care at their offices or at the facilities of the health department
24 obstetrical clinic;
- 25 (3) No physician shall be required to assume management of the care
26 of any obstetrical patient if the level of care required for that
27 patient is beyond the professional competence of that physician;
- 28 (4) Physicians eligible for payment under this program shall be
29 licensed to practice medicine in this State;
- 30 (5) Participating physicians shall provide complete obstetrical care for
31 covered patients including prenatal care and delivery; provided,
32 however, physicians in a county without a facility for obstetrical
33 delivery are still eligible if they provide only prenatal care;

- 1 (6) The liability insurance rates for obstetrical care to be used to
2 determine compensation under this program shall be based on
3 obstetrical premiums of \$1,000,000/\$1,000,000 coverage at a mature
4 rate; and
- 5 (7) Any physician compensated under this program shall not refuse to
6 provide obstetrical care for any patient based on the patient's
7 economic status or ability to pay.
- 8 Sec. 2. This act shall become effective July 1, 1988.

JRC

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1989

S

S 830

1989-023

SENATE DRS7620-LK263(3.17)

PRINCIPAL CLERK

Short Title: Rural Obstetrical Care Funds.

(Public)

Sponsors: Senators Swain and Winner.

Referred to:

- 1 A BILL TO BE ENTITLED
2 AN ACT TO APPROPRIATE FUNDS TO THE DEPARTMENT OF HUMAN
3 RESOURCES FOR THE RURAL OBSTETRICAL CARE INCENTIVE
4 PROGRAM.
5 The General Assembly of North Carolina enacts:
6 Section 1. There is appropriated from the General Fund to the
7 Department of Human Resources the sum of one million dollars (\$1,000,000) for the
8 1989-90 fiscal year and the sum of two million dollars (\$2,000,000) for the 1990-91
9 fiscal year to fund the rural obstetrical care incentive program.
10 The rural obstetrical care program shall compensate family physicians
11 and obstetricians who agree to provide prenatal and obstetrical services in counties
12 that are underserved with regard to these services. The Commission for Health
13 Services shall adopt rules determining the counties that are underserved with respect
14 to obstetrical care that are to be part of this program, the scope of the obstetrical
15 services that are to be provided by a physician for that physician to be eligible to
16 receive assistance under the program, and the amount and nature of the assistance to
17 be provided to eligible physicians. Specific rules issued by the Commission for
18 Health Services governing this program shall include:
19 (1) A physician who provides obstetrical care in a county that is
20 designated as being underserved for prenatal and obstetrical care

1 by the Commission for Health Services will be compensated for
2 either the difference between his premiums with obstetrical care
3 coverage and his premiums without obstetrical care coverage, or
4 six thousand five hundred dollars (\$6,500), whichever is less;

5 (2) Physicians providing obstetrical care through an arrangement with
6 their local health department shall have the option of providing
7 the care at their offices or at the facilities of the health department
8 obstetrical clinic;

9 (3) No physician shall be required to assume management of the care
10 of any obstetrical patient if the level of care required for that
11 patient is beyond the professional competence of that physician;

12 (4) Physicians eligible for payment under this program shall be
13 licensed to practice medicine in this State;

14 (5) Participating physicians shall provide complete obstetrical care for
15 covered patients including prenatal care and delivery; provided,
16 however, physicians in a county without a facility for obstetrical
17 delivery are still eligible if they provide only prenatal care;

18 (6) The liability insurance rates for obstetrical care to be used to
19 determine compensation under this program shall be based on
20 obstetrical premiums of \$1,000,000/\$1,000,000 coverage at a mature
21 rate; and

22 (7) Any physician compensated under this program shall not refuse to
23 provide obstetrical care for any patient based on the patient's
24 economic status or ability to pay.

25 Sec. 2. This act shall become effective July 1, 1989.

Signed into Law by
ARIZONA GOVERNOR MOFFORD
June 28, 1989

Senate Engrossed House Bill

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

ISSUED BY
JIM SHUMWAY
SECRETARY OF STATE

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.

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

2 Section 1. Appropriation; purpose; exemption

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

28 I. The appropriation made in this section is exempt from section
29 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.

Medical Indemnity Corporation of Alaska

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 discuss this with me. I hope we can get together in the fall.

Regards.

A handwritten signature in cursive script, appearing to read "Mary".

Mary A. Pierce
Executive Director

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"

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.

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

2 Section 1. Appropriation; purpose; exemption

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

28 I. The appropriation made in this section is exempt from section
29 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

HOUSE COMMITTEE REPORT

(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 Judiciary Committee

ADOPTS: _____ letter of intent

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

- fiscal impact _____
- zero fiscal note _____
- zero with analysis _____
- fiscal note(s) _____
- zero fiscal note(s) _____
- zero fn/analysis _____

SIGNING DO PASS:

[Handwritten signatures and names]
 _____ *Finkestein*
 _____ *Dunley*
 _____ *Matthews*
 _____ *Boyer*

SIGNING:
(Check approp. column)

	Do Not Pass	No Rec	Amend
<i>[Signature]</i>			
<i>[Signature]</i>			
<i>[Signature]</i> <i>Leaman</i>			X
<i>[Signature]</i> <i>Collins</i>	X		
<i>creates more problems than it solves!</i>			
<i>[Signature]</i> <i>Boucher</i>	X		
<i>[Signature]</i>			

[Handwritten Signature]
Chairman's Signature

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

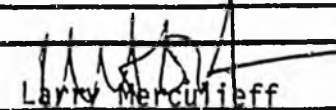
POSITIONS:

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: 
 Agency: Department of Commerce & Economic Development

Date: 6 Feb 90

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



**STATE OF ALASKA
OFFICE OF THE GOVERNOR
BILL ANALYSIS**

DEPARTMENT Commerce & Econ. Dev.	DIVISION Insurance	BILL NUMBER HB 350	SPONSOR Donley and Gruenberg
SHORT TITLE OF BILL An Act creating the Alaska Medical Malpractice Matching Fund; and providing for an effective date			
DEPARTMENT PORTION Neutral			
PREPARED BY <i>[Signature]</i>	DATE 11/21/89	COMMISSIONER'S SIGNATURE <i>[Signature]</i>	DATE 12 Dec 89

SUMMARY

OTHER AGENCIES AFFECTED BY BILL	CONSTITUENT GROUPS 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.

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

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%
 18% of total doctors reside in Anchorage

	<u>Delivering or Had Been Delivering Babies</u>	<u>Not Doing Deliveries</u>
Total	131	190
Uninsured	27 or 20.6%	21 or 11%
Uninsured Located	14 - Anchorage 7 - Kenai Peninsula 2 - Fairbanks 2 - North 2 - Southeast	14 - Anchorage 4 - Kenai Peninsula 3 - 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
 Executive Director, MICA

Alaska State Medical Association

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

December 29, 1989

Dear Colleague:

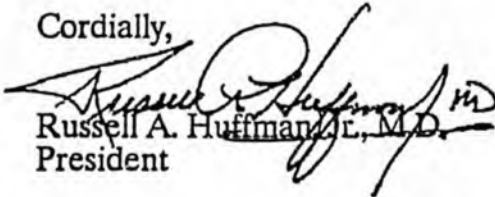
Enclosed is a survey intended to derive some needed information from Alaska physicians. As most of you know, the state medical association is taking a leadership role in trying to help the state legislature with the complicated issues surrounding tort reform and/or liability insurance. Before we can 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.

X
The code in the right hand corner is in three parts. The first part: G = Group, S = Solo (single practitioner). 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

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.

*Dave or Ginger,
sent 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 physician 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 Practitioner doing obstetrics and those who were not. Assuming the same scenario as above and that the Family Practitioner not doing obstetrics was doing minor surgery the difference would be \$14,046. In other words, the Family Practitioner 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

<u>RATE CHANGES</u>	<u>M.D.</u>	<u>HOSPITAL</u>
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. +186% (Changed to Class 2B)
Emergency Medicine +166% (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 208
 ANCHORAGE, ALASKA 99508
 (907) 568-8414

February 23, 1990

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

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* - Anchorage includes Mat-Su Valley

** - covered by Federal Government

General Surgeons (C-Section only)

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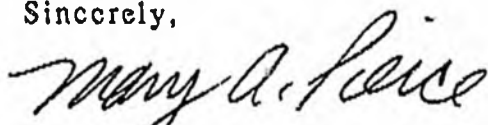
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Sincerely,



Mary A. Pierce
Executive Director, MICA

Amendment to
CS HB 350

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

p 3 Line 18
~~is~~ renumber subsection (2)
as subsection (3)

p 3 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 20 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)

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

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.

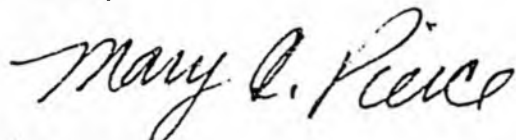
Finally, we have some concerns if we are to administer this fund.

- 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
Executive Director

STATE OF ALASKA
THE LEGISLATURE

POUCH Y STATE CAPITOL
JUNEAU ALASKA 99811
907-465 3800

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM

February 20, 1990

SUBJECT: Alaska medical malpractice matching fund -
HB 350

TO: Representative Dave Donley

FROM: Michael F. Ford *m.f.*
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

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:

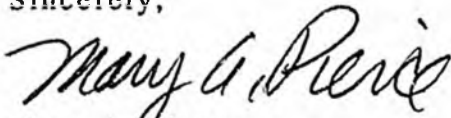
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I hope that this letter and the attached premium schedule better answers your questions. If you have any further questions, please feel free to call me.

Sincerely,



Mary A. Pierce
Executive Director

MAP/blb

Enclosure

BOARD OF GOVERNORS:

William G. Brock, Chairman
David J. Frazier, 1st Vice-Chairman
Ronald W. Keller, M.D., 2nd Vice-Chairman
Kim C. Smith, M.D., Member At Large
David S. Grauman, M.D.
C. Keith Campbell
Patricia L. Miles
Clarice Dukeminier, M.D.
Vern Carlson

ADMINISTRATIVE SERVICES:

Mary Pierce, Executive Director
Janet Sloan Johnston, Claim Manager
Penny Chmielewski, Risk Management Coordinator
Art Stanford, Underwriting Manager

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 entitled CLAIMS-MADE PREMIUM SCHEDULE.

All policies issued by MICA are renewed on January 1 of each year. Your first years and renewal rates are pro-rated from the first date of coverage (inception date) of the original policy. For example, if your continuous coverage became effective on July 1, 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 accomplished by 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 physician* 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 negligent 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)

Ophthalmology (excluding Radial Keratotomy)

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 because 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

* 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.

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