Medical Mal-Practice:

Proposed Legis-lation

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: Proposed Legislation - Experience rating

The attached work draft (Work Order No. 6-1639A, by Ford, dated 10/2.89) requires insurers who offer medical malpractice or commercial liability insurance to "experience rate" their insureds. Experience rating plans under this provision are subject to standard rate filing requirements under AS 21.39.040-050.

The draft legislation seeks to address current problems with classification and rating for medical providers and other commercial liability insureds by permitting the development of "safe doctor" rates and other rating practices that more fairly distribute the cost of insurance among premium-paying consumers.

dd/gbi89
b/exp

6-1639A
Ford
10/2/89

IN THE HOUSE

BY THE LABOR AND COMMERCE COMMITTEE

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to insurance rates."

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

* Section 1. AS 21.39 is amended by adding a new section to read:

Sec. 21.39.035. MANDATORY EXPERIENCE RATING. In addition to the rate requirements of AS 21.39.030, an insurer who offers malpractice insurance or commercial liability insurance shall develop an experience rating plan and shall apply the experience rating to each person who purchases malpractice insurance or commercial liability insurance. The experience rating plan required under this section is subject to the rate filing requirements of AS 21.39.040 - 21.39.050.

NATIONAL INSURANCE
CONSUMER ORGANIZATION

How To

Tame the Insurance Industry Cycle

and

Make the Legal System More Efficient:

A Suggested Legislative Agenda for 1987

by

J. Robert Hunter, President
and
Jay Angoff, Counsel
National Insurance Consumer
Organization

Presented at the Annual
Meeting of the National
Conference of State
Legislatures
New Orleans, Louisiana
August 8, 1986

121 N. Payne Street
Alexandria, Virginia 22314
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attached as Exhibits H1 and H2.

3. Require experience rating "SAFE Doctor Rates"

Good drivers pay less than bad drivers for auto insurance, and homeowners who are good risks pay less than those who are bad risks. In contrast, in most states, good doctors and bad doctors pay the same rate: a doctor who has been successfully sued for malpractice several times pays the same rate as a doctor who has never had a claim against him. Many other professionals and small businesses also pay a set rate regardless of their individual claims experience, i.e., they are not experience-rated.

By requiring insurance companies to experience-rate all professional and commercial risks, just as they experience-rate drivers and homeowners, states could reduce insurance rates for most insureds. This is particularly true for medical malpractice insurance, since studies have consistently shown that a very small percentage of doctors is responsible for a very large amount of the malpractice. 11/ Absent experience rating, therefore, the majority of doctors, who rarely if ever engage in malpractice, subsidize the small minority of doctors who are frequent malpractitioners.

11/ See, e.g., Michigan Report on the Liability Crisis at 11 (1985) (19.3% of doctors accounted for 72.2% of claims; 58.1% had no claims); Florida Insurance Commissioner, Closed Claims Study of Medical Malpractice Insurance, 1975-82 (1983) (0.7% of doctors accounted for 24% of claims; one doctor for 31 claims); S. Ferber & B. Sheridan, "Six Cherished Malpractice Myths Put To Rest," 52 Medical Economics 150 (1975) (0.6% of Los Angeles doctors accounted for 30% of all payments).

A bill requiring experience rating is attached as Exhibit I1. Regulations specifying how doctors can be experience rated are attached as Exhibit I2.

3. Establish flex-rating

If insurance companies were fully subject to the antitrust laws, then rate regulation might be unnecessary; the market would determine the proper level of rates. However, because under the McCarran-Ferguson Act insurers may legally fix prices and engage in other anticompetitive activity, regulation of insurance rates is essential.

To allow the market to work as competitively as possible despite McCarran-Ferguson, insurance companies should be permitted to raise or cut their rates without approval by the insurance commissioner within a "zone of reasonableness" - say, 15% above and 15% below the existing rate. Above or below that rate, however, states should not permit a rate to take effect unless and until the insurance comissioner approves the rate. Requiring such prior approval of rates except those within the zone of reasonableness should both smooth out the insurance industry cycle and enhance competition in the industry.

A bill requiring prior approval of insurance rates except those within a zone of reasonableness - so called "flex-rating" - is attached as Exhibit J.

4. Beef up enforcement

It is well-established that state insurance departments

(NY)

EXHIBIT I-1

(e) The superintendent shall by regulation establish reasonable standards for rating plans (including experience rating plans, schedule rating plans, individual risk premium modification plans and expense reduction plans) designed to modify rates in the development of premiums for individual risks insured in a property/casualty market. Such standards shall permit recognition of expected differences in loss or expense characteristics, and shall be designed so that such plans are reasonable and equitable in their application, and are not unfairly discriminatory, violative of public policy or otherwise contrary to the best interests of the people of this state. Such standards shall not prevent the development of new or innovative rating methods which otherwise comply with this article. Such rating plans shall be filed or refiled by insurers in compliance with the regulation. The superintendent shall review such plans, and may without a hearing disapprove a plan that does not comply with the regulation. The regulation shall establish maximum debits and credits that may result from the application of a rating plan, shall encourage loss control, safety programs and other methods of risk management, and shall require insurers to maintain documentation of the basis for the debits or credits applied under any plan. Once it has been filed and approved, use of the rating plan shall become mandatory and such plan shall be applied uniformly for eligible risks in a manner that is not unfairly discriminatory.

EXHIBIT I-2

INSURANCE DEPARTMENT OF THE STATE OF NEW YORK

REGULATION NO. 124

(11 NYCRR 152)

Physicians and Surgeons Professional Insurance Merit Rating Plan

I, SALVATORE R. CURIALE, First Deputy Superintendent acting on behalf of JAMES P. CORCORAN, Superintendent of Insurance of the State of New York, pursuant to the authority granted by Sections 201, 301 and 2343(d) of the Insurance Law of the State of New York, do hereby promulgate the following Part 152 of Title II of the Official Compilation of Codes, Rules and Regulations (Regulation No. 124), to take effect immediately upon filing with the Secretary of State, to read as follows:

152.1 Preamble

(a) Section 2343(d) of the Insurance Law requires that the Insurance Department promulgate a regulation establishing a Physicians and Surgeons Professional Liability Merit Rating Plan which Regulation was to take effect on January 1, 1986. A merit rating plan is a system of rules for imposing rate surcharges or credits, within the existing class and territory matrix, based upon an individual's past history of claims or disciplinary actions. The plan is intended to produce a more accurate individual premium by using past claim history to predict the likelihood of future claims.

(b) Some insurers currently have a formal merit rating plan, while others impose surcharges and credits on an ad hoc judgmental basis. This regulation establishes a uniform plan for use by all insurers, which supercedes all existing plans. The Department believes it is in the best interests of insurers, physicians, and the public to maintain stability in the rating system by requiring all insured physicians to be experience-rated under the same set of criteria. The plan, which applies to all claims-made and occurrence policies, is intended to be revenue-neutral: i.e., any additional funds generated by surcharges must be offset by a rate discount factor that is applied to the base rates: over the long term and for all insurers within the entire system.

152.2 Definition

As used in this Part:

(a) The term "claim" shall mean written notice or demand upon the insured, including suit, filed by a claimant or other person acting on behalf of the claimant, and received by the insurer, that alleges injuries or damages sustained from an incident. A single incident may result in no more than one chargeable loss for each physician.

b) The term "chargeable loss" shall mean: for claims closed prior to July 1, 1981, the sum of all indemnity payments on any one closed claim must be at least $15,000; for claims closed or outstanding on or after July 1, 1981, the sum of all indemnity payments on any one closed or outstanding claim must be at least $30,000.

152.3 Procedures

(a) Evaluation period to be used:

Chargeable losses paid in the ten-year review period and disciplinary actions imposed in the five-year period prior to the latest policy effective date shall be included for evaluation purposes. If, for any claim, the length of time between the occurrence and settlement dates is more than thirteen years, then such claim can no longer be, or become, a chargeable loss even though settlement occurs in the ten year review period. Physicians licensed to practice for less than ten years shall be rated only on their years of practice. In issuing new and renewal policies for the period beginning July 1, 1986, insurers shall use the full ten-year experience period (or less, for physicians licensed less than 10 years). Upon request, physicians, insurers, and managers of insurance programs shall furnish to current insurers claims and disciplinary information necessary to calculate an accurate surcharge. Existing insurers shall request and obtain this information.

(b) Surcharges for disciplinary actions:

The following surcharges shall apply where there has been:

1. Licensing Board disciplinary proceedings within the past five years:

i. License revoked in any state: surcharge 100%.

ii. License suspended in any state: surcharge 75%.

iii. Probation invoked in any state: surcharge 50%.

2. Hospital disciplinary proceedings involving malpractice or incompetency within the past five years (excluding disciplinary proceedings for lateness in recordkeeping and/or lateness in submitting proof of insurance coverage):

i.Privileges revoked by any hospital: surcharge 100%.

ii.Privileges restricted or suspended by any hospital: surcharge 75%.

(c) Assignment of points for Chargeable Losses:

For each chargeable loss, one point shall be assigned. These "points" generate surcharges according to the following schedule of percentages, which is based on the specialty classifications filed by the Medical Malpractice Insurance Association (Note: these factors will be adjusted periodically as more experience data becomes available):

Surcharge Points	1	2	3	4	5	6	7 or more
1-7 Downstate	0	0	10%	35%	80%	130%	200%
8-14 Downstate	0	10%	35%	70%	110%	150%	200%
1-7 Upstate	0	10%	35%	70%	110%	150%	200%
8-14 Upstate	5%	15%	45%	85%	120%	160%	200%

Surcharges are developed by determining the chargeable losses paid within the evaluation period, adding the number of points for each loss, and multiplying the otherwise applicable premium by 100% plus the surcharge. For example, if a physician's base rate for his class and territory is $50,000, and he has accumulated seven surcharge points, his premium is:

200% (surcharge) + 100% (base) = 300%

300% of $50,000 = $150,000

Surcharges for disciplinary actions are added to any surcharges generated by chargeable losses. For example, if an upstate Class 10 physician's base rate for his class and territory is $10,000, and he has accumulated two surcharge points and has had probation invoked in any state, his premium is:

15% (for two points) + 50% (for probation) +100% (base) = 165%

165% of $10,000 = $16,500

In no event shall the total surcharge from both chargeable losses and disciplinary actions exceed 200%.

(d) Credits:

Insurers who insure physicians in the first year of practice, or physicians in part-time practice (e.g., semi-retired or in full-time teaching) must file an appropriate rate credit. Any surcharge or credit generated by other provisions of this regulation will apply to the reduced premium. No credits other than those specified in this regulation will be permitted.

(e) Appeals Procedure:

Insurers shall establish and file for approval a mechanism for physicians to (1) appeal the determination of the insurer and (2) explain the circumstances of their chargeable losses or disciplinary procedures. Surcharge "points" shall be waived or reduced by insurers if circumstances indicate that they are not truly predictive of future claims. While the surcharge is

being appealed, the insured must pay the applicable rate for his class and territory including all surcharges (whether or not they are being appealed).

(f) Refund of Surcharge:

Surcharges must be returned if: 1)indemnity payments, which generated the surcharge, are subsequently reduced below the chargeable level, or 2)upon appeal, as outlined in Subsection e above, it is determined that a disciplinary procedure or chargeable loss is not truly predictive of future claims. The method for refund of the surcharge is at the option of the insurer but shall be reasonably prompt and uniform for all its insureds. Surcharges shall be returned for the policy period in which the payment was reduced or the surcharge was successfully appealed and for two prior policy periods, if applicable.

(g) Reclassification of Physician:

If a physician is reclassified from a higher-rated to a lower-rated specialty, "points" assigned for incidents which were not related to the practice of the lower-rated specialty shall not be used for merit rating purposes.

(h) Notice to Insureds:

When a policy has been surcharged under a merit rating plan, insurers are directed to state prominently, either on the declarations page or the premium bill, or on a notice attached to the declarations page or premium bill, the following, or its substantive equivalent:

"Your premium rates are higher than they otherwise would be because, during the measuring experience period which applied to your insurance, you had the following chargeable losses or disciplinary actions under our merit rating plan. This plan has been filed with and approved by the New York Insurance Department pursuant to Regulation No. 124 of the Department. The attached description of our merit rating plan includes a list of events for which we may surcharge you, the circumstances under which surcharges may be removed and refunded, and the procedure you should follow if you wish to appeal this surcharge. We trust this will answer any questions you have concerning your surcharge. If you have any further questions, you may call us at ."

152.4 Alternative Plans:

Subject to the Superintendent's approval, a plan may be submitted which varies in one or more aspects from the rules established in this Part if the unique circumstances of the insurer warrant exceptional treatment, and if credible data supports the proposal. The burden of demonstrating entitlement to a variance shall rest with the insurer. This Regulation is not intended to proscribe an insurer from adopting a retrospective rating plan which is approvable by the Superintendent upon a determination that the plan is not inconsistent with other provisions of this Regulation and is based upon demonstrable actuarial evidence.

152.5 Implementation:

All insurers shall adopt and submit a merit rating plan for approval by the Superintendent, except as hereafter provided, by August 15, 1986, to apply to policies issued or renewed on and after July 1, 1986. The appeals procedure and Notice required by this Part shall be adopted and submitted by August 15, 1986. Following approval of each insurer's merit rating plan, the offsets that must be applied to the base rates in order to insure that these plans are revenue neutral, should be incorporated in all subsequent rate filings. These offsets shall be periodically reviewed by all insurers.

I, SALVATORE R. CURIALE, First Deputy Superintendent acting on behalf of JAMES P. CORCORAN, Superintendent of Insurance of the State of New York, do hereby certify that the foregoing is Regulation 124 (11 NYCRR 152) promulgated by me on June 12, 1986, as a final measure pursuant to the authority granted by Sections 201, 301 and 2343(d) of the Insurance Law.

Pursuant to Section 202(6) of the State Administrative Procedure Act, this regulation was previously promulgated as an Emergency Measure on December 30, 1985, February 28, 1986 and May 2, 1986. Prior notice of this regulation was published in the State Register on January 15, 1986, March 19, 1986 and May 21, 1986 as an emergency measure and on January 15, 1986 as

a proposed agency action. No other publication or other prior notice is required by statute.

Dated: June 12, 1986

JAMES P. CORCORAN
Superintendent of Insurance

By:

Salvatore R. Curiale
First Deputy Superintendent

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: Proposed Legislation - Physician classification for medical malpractice premiums.

The attached work draft (Work Order No. 6-1641A, by Ford, dated 10/2/89) limits insurers to using no more than four classifications for physicians in order to determine medical malpractice liability insurance premiums.

The rationale behind limiting insurers to four categories is outlined in the enclosed excerpt from Robert Hunter's report from the National Insurance Consumers Organizations (NICO).

Currently MICA (Medical Indemnity Corporation of Alaska), Alaska's largest medical malpractice insurer, breaks physicians into seven categories to determine rates. Our second largest insurer, MIEC (Medical Insurance Exchange of California), uses ten.

Included in your files is a House Research Agency report regarding medical malpractice premiums and a more recent Legislative Research Report on some of the anticipated effects of the proposed legislation. We expect testimony from medical providers and medical insurers such as MICA at our November 29 and 30 hearings.

dd/gbi89
b/four

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P. O. Box Y, State Capitol
Juneau, Alaska 99811-3100
Mail Stop 3100
(907) 465-3991

March 15, 1989

MEMORANDUM

TO: Representative Peter Goll

ATTN: Hayden Kaden

FROM: Karen Oakley KO
Legislative Analyst

RE: **Medical Malpractice Premiums Paid by Alaska Doctors**
Research Request 89.297

You asked how many doctors are in private practice in rural Alaska communities, and whether these doctors pay more for medical malpractice insurance than do other doctors. You also asked if the federal government pays medical malpractice premiums for the doctors it employs in Alaska.

In summary, there are only a handful of doctors in private practice living in rural Alaska communities. Medical malpractice premiums paid by Alaska doctors depend on the type of medicine practiced and the limits of liability chosen; the location of the practice does not directly affect premium cost. Liability for malpractice by federally-employed doctors is assumed by the federal government.

Geographic Distribution of Alaska Doctors

Currently, there are approximately 825 physicians working in Alaska. The Alaska State Medical Association (ASMA) Directory listed 827 doctors in Alaska in 1987. The Division of Occupational Licensing reported a similar number--833 doctors--with current licenses in August 1988.

Nearly 75 percent of doctors working in Alaska are in private practice. The major government employers of doctors in Alaska are the military, which employs 97 doctors, and the U.S. Public Health Service (PHS) (including the Indian Health Service), which employs 111 doctors. At least some of the PHS doctors are itinerants based in larger communities who travel to remote communities.

In Table 1, the number of doctors in private practice residing in each house election district is presented. We were not able to determine to what extent doctors in private practice provide services to communities other than the community in which the doctor resides. Conceivably, some private doctors living in urban areas travel to rural areas to provide services.

TABLE 1
NUMBER OF PRIVATE PHYSICIANS OF VARIOUS SPECIALTIES RESIDING IN EACH HOUSE ELECTION DISTRICT
(LIST RANKED BY THE NUMBER OF PRIVATE PHYSICIANS IN THE SPECIALTY)

		HOUSE ELECTION DISTRICT															
SPECIALTY	TOTAL	1	2	3	4	5	6	7-15	16	17	18-21	22	23	24	25	26	27
Family & General Practice	151	6		4	10	14	2	77	13		15				1	2	7
Internal Medicine	80	3		3	5	1		53			13						2
Pediatrics	44	2			2	1		26	2		10						1
Surgery	44	2		2	3	2		22	2		9						2
Obstetrics-Gynecology	42	1				1		29	3		8						
Orthopedic Surgery	41	2			2	1		24	1		10						1
Emergency Medicine	37				3	5		19	4		6						
Psychiatry	34	1			2			26			5						
Radiology	25	1			2	1		14	1		6						
Anethesiology	25	1				1		18	1		4						
Opthalmology	18				1	1		12			4						
Otolaryngology	14				1			9	1		3						
Pathology	12							8	1		3						
Cardiology	8							8									
Urology	7					1		4			2						
Neurology & Neurology Surgery	7							6			1						
Neonatal & Perinatal Medicine	7							7									
Dermatology	6				1			4			1						
Physical Medicine & Rehabilitation	4							4									
Occupational Medicine	4							4									
Acupuncture	2							2									
Sports Medicine	2							1			1						
Gastroenterology	2							2									
Family Therapy	2							1		1							
Public Health & Preventive Medicine	1							1									
Aerospace Medicine	0																
Primary Care	0																
TOTAL PRIVATE PHYSICIANS	619	19	0	9	32	29	2	381	29	1	101	0	0	0	1	2	13
TOTAL PHYSICIANS	827	24	1	19	36	29	2	496	29	3	138	4	6	0	17	7	16
PERCENT IN PRIVATE PRACTICE	74.8	79.2	0.0	47.4	88.9	100.0	100.0	76.8	100.0	33.3	73.2	0.0	0.0	0.0	5.9	28.6	81.3
PERCENT OF TOTAL IN PRIVATE PRACTICE		3.1	0.0	1.5	5.2	4.7	0.3	61.6	4.7	0.2	16.3	0.0	0.0	0.0	0.2	0.3	2.1

SOURCE: ALASKA STATE MEDICAL ASSOCIATION DIRECTORY (1987).

Prepared by the House Research Agency, March 1989 (89.297A).

These data indicate that very few doctors in private practice reside in rural areas. Four election districts that are generally considered to be rural (2, 22, 23, and 24) have no resident doctors in private practice.[1] The majority of doctors in private practice reside in Anchorage and Fairbanks (78 percent).

Twenty-four percent of all private doctors are in Family and General Practice. In those election districts with few resident private doctors, those doctors are typically in family practice. Most of the private specialists reside in Anchorage or Fairbanks.

For further information on the geographic distribution of doctors and other health care providers in Alaska, see House Research Memorandum 89.004, which is provided as Attachment A.

Medical Malpractice Premiums Paid by Alaska Doctors

Doctors employed by the federal government are not covered by medical malpractice insurance; instead, the federal government assumes liability for malpractice by its doctors. An individual who is injured by a federal government doctor in the normal course of the doctor's job may sue the federal government under the Federal Tort Claims Act. When the injured individual is successful in their claim against the government, damages are paid from a fund administered by the U.S. Department of Justice. Further information on medical malpractice coverage of federal government doctors is found in House Research Memorandum 87.097 (Attachment B).

Doctors in private practice obtain medical malpractice insurance from insurance companies.[2] According to the Alaska Division of Insurance Annual Report for FY 88, 22 insurance companies wrote medical malpractice insurance policies for doctors practicing in Alaska in that year. Attachment C, from the report, shows the percent of market share written by each company. A total of $14.4 million in direct premiums written was reported. Three companies accounted for 92.5 percent of the total dollar value of premiums written. These companies were the Medical Indemnity Corporation of Alaska (MICA), Medical Insurance Exchange of California (MIEC), and the Continental Casualty Company.

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[1]One election district, Election District 24, has no resident doctors.

[2]The state does not require proof of insurance from doctors licensed to practice medicine in Alaska, and it is possible that some doctors do not have medical malpractice insurance.

The MICA had 48.3 percent of the medical malpractice market in Alaska in FY 88. The MICA was established by the Alaska Legislature in 1976 in response to the liability insurance crisis occurring at that time which severely reduced the availability of medical malpractice insurance in Alaska and elsewhere.[3] The current premium schedule of the MICA is provided in Attachment D. The premium paid by a doctor depends upon the type of medicine the doctor practices and the limits of liability the doctor chooses. The MICA does not take the location of a doctor's practice into consideration in determining the premium.

The second largest provider of medical malpractice insurance to Alaska doctors is the MIEC. The MIEC is doctor-owned. The Alaska State Medical Association brought MIEC to Alaska around 1979 to provide doctors with a choice of insurance coverage. The current premium schedule of the MIEC is provided in Attachment E. As for the MICA, the premium schedule depends upon the doctor's specialty and limits of liability; the location of the doctor's practice is not taken into consideration.

In FY 88, the Continental Casualty Company, which is based in Chicago, wrote $1.6 million in direct medical malpractice premiums, for an 11 percent market share. According to Renee Smith, of the company, Continental uses the standard ISO rates in determining the premiums to charge Alaska doctors that insure with them.[4] She could not provide a premium schedule and was not sure how their rates compared with those of MICA or MIEC.

Premiums charged by both MICA and MIEC are based on actual Alaska loss experience data. Although none of the companies takes the precise location of the doctor's practice within Alaska into account when determining the premium, the doctor's location and the type of medicine practiced are often related; thus, the doctor's location may indirectly affect the doctor's medical malpractice insurance costs. Doctors practicing in rural areas are more likely to be generalists, rather than specialists. Rural doctors would therefore be more likely to be placed in the lower risk classifications and consequently pay less for medical malpractice insurance than specialized practioners.

* * *

I hope you find this information useful. If I can provide any further information, please let me know.

Attachments

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[3]For further information on the Medical Indemnity Corporation of Alaska, see House Research Memorandum 81.010.

[4]The ISO is one of the major ratings organizations.

ATTACHMENT A
House Research Memorandum 89.004

ATTACHMENT B
House Research Memorandum 87.097

ATTACHMENT C
Alaska Division of Insurance Annual Report FY 88
Companies Writing Medical Malpractice Insurance
Policies for Alaska Doctors

From Division of Insurance Annual Report for FY88

PROPERTY AND CASUALTY MARKET SHARE
11 - MEDICAL MALPRACTICE

RANK	COMPANY NAME	PERCENT OF MARKET	DIRECT PREMIUMS WRITTEN
1	MEDICAL INDEMNITY CORP OF AK	48.32	6,937
2	MEDICAL INS EXCHANGE OF CALIFORNIA	33.27	4,777
3	CONTINENTAL CASUALTY CO	10.93	1,570
4	NATIONAL UNION FIRE INS CO OF PITTSB	3.04	437
5	ST PAUL FIRE & MARINE INS CO	1.13	163
6	AETNA CASUALTY & SURETY CO	.90	130
7	NATIONAL CHIROPRACTIC MUTUAL INS CO	.59	85
8	CHICAGO INS CO	.45	65
9	AMERICAN CASUALTY CO OF READING	.45	65
10	TRAVELERS INDEMNITY CO	.41	59
11	NATIONAL FIRE INS CO OF HARTFORD	.24	35
12	INS CO OF THE STATE OF PA	.07	11
13	RLI INS CO	.06	9
14	AMERICAN CONTINENTAL INS CO	.03	5
15	ALASKA PACIFIC ASR CO	.03	5
16	PACIFIC EMPLOYERS INS CO	.02	4
17	HARTFORD FIRE INS CO	.01	2
18	INTERSTATE INDEMNITY CO	.00	1
19	JEFFERSON INS CO OF NY	.00	1
20	ST PAUL MERCURY INS CO	.00	-1
TOTAL FOR TOP	20 RANKED INSURERS	99.95	14,360
TOTAL FOR ALL	22 INSURERS WRITING THIS LINE	99.93	14,356

ATTACHMENT D
Medical Indemnity Corporation of Alaska
1989 Premium Schedule

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, mo mployees 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%

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.

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
Opthalmology (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 Reconstructrive Surgery, excluding cosmetic surgery
Urology
Gynecology (No Obstetrics)

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 lenghth 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.

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.

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	3,593	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	14,205
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	24,6.J	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 E
Medical Insurance Exchange of California
1989 Premium Schedule

MIEC

Medical Insurance Exchange of C' 'fornia

ALASKA

1988 Coverage Classification and Premium Schedule

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

Class	Specialty
2	Administrative Medicine
2	Allergy
8	Anesthesiology
5	Assisting at Surgery
4	Cardiology*
9	Cardiovascular Surgery
8	Colon & Rectal Surgery
3	Dermatology, Excluding Hair Transplants
5	Dermatology, Including Hair Transplants
7	Dermatology – liposuction
8	Emergency Medicine
3	Endocrinology*
	Family Practice General Practice
3	– No Surgery
5	– Less than 5% of income from performance of Surgery
8	– 5% or more of income from performance of Surgery
10	– Including Obstetrics
9	– Including 5% or more income from any combination of Orthopedics, Gynecology, ENT Surgery
3	Gastroenterology*
3	General Preventive Medicine
8	General Surgery
8	Gynecology (Only)
8	Hand Surgery
8	Head & Neck Surgery
3	Hematology*
6	Industrial Medicine
3	Infectious Diseases*
3	Internal Medicine*
4	Neonatology*
3	Neoplastic Diseases*
3	Nephrology*
4	Neurology, Excluding Invasive Procedures
5	Neurology, Including Invasive Procedures
10	Neurological Surgery
3	Nuclear Medicine*
10	OB-GYN
3	Occupational Medicine (Not Industrial)
4	Ophthalmology, Excluding Radial Keratotomy
7	Ophthalmology, Including Radial Keratotomy or 5% or more from cosmetic surgery
9	Orthopedics, Excluding Spinal Surgery and use of Chymopapain
10	Orthopedics, Including Spinal Surgery and use of Chymopapain
8	Otolaryngology
9	Otolaryngology – 5% or more from Cosmetic Surgery
2	Pathology
3	Pediatrics
4	Pediatric Cardiology
8	Pediatric Surgery
3	Physical Medicine and Rehabilitation
8	Plastic Surgery
1	Psychiatry**
1	Psychiatry, Child**
2	Public Health
3	Pulmonary Diseases*
7	Radiology, Diagnostic and Therapeutic
4	Radiology, Diagnostic Only*
7	Radiology, Therapeutic Only*
3	Rheumatology*
8	Thoracic Surgery, Excluding Cardiovascular
4	Urgent Care Medicine
7	Urology

*Includes all procedures, including Invasive Diagnostic Procedures, considered usual and customary to and within the training and purview of the specialty.

**Without ECT or drug shock therapy. With ECT or drug shock therapy, use Class 3.

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. Full Time Employed Physicians must carry limits at least equal to employer. Employer will be charged a percentage of the premium charged for the employed physician's classification at employer's limits.

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. It also covers certain liabilities to injured parties 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. Refer to the policy for coverage specifics.

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 physician'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.

PREMIUM: Individuals and solo professional corporation: $1,800 per year. Individuals with more than 10 employees, medical corporations with more than one physician shareholder, partnerships, laboratories and all other non-individual policyholders should contact MIEC for a special application and premium quotation

MIEC **Medical Insurance Exchange of California**

ALASKA

Claims Made Professional Liability Premium Schedule

Effective June 1, 1988

Limits of Liability: 500,000 Each Claim / 1,500,000 Annual Aggregate

DOCTORS COVERAGE CLASSIFICATIONS	FIRST YEAR RATES RETROACTIVE DATES: 01/01/88 OR LATER		SECOND YEAR RATES RETROACTIVE DATES: 01/01/87 - 12/31/87		THIRD YEAR RATES RETROACTIVE DATES: 01/01/86 - 12/31/86		FOURTH YEAR RATES RETROACTIVE DATES: 01/01/85 - 12/31/85		FIFTH YEAR RATES RETROACTIVE DATES: 08/01/75 - 12/31/84	
	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY
1. COVERAGE CLASS 1	1,900	475	3,732	933	4,744	1,186	5,120	1,280	5,564	1,391
2. COVERAGE CLASS 2	2,416	604	4,748	1,187	6,036	1,509	6,516	1,629	7,080	1,770
3. COVERAGE CLASS 3	3,448	862	6,784	1,696	8,620	2,155	9,312	2,328	10,116	2,529
4. COVERAGE CLASS 4	3,968	992	7,800	1,950	9,912	2,478	10,708	2,677	11,632	2,908
5. COVERAGE CLASS 5	6,036	1,509	11,868	2,967	15,084	3,771	16,292	4,073	17,700	4,425
6. COVERAGE CLASS 6	6,724	1,681	13,224	3,306	16,808	4,202	18,152	4,538	19,724	4,931
7. COVERAGE CLASS 7	8,620	2,155	16,952	4,238	21,548	5,387	23,272	5,818	25,284	6,321
8. COVERAGE CLASS 8	12,412	3,103	24,412	6,103	31,032	7,758	33,512	8,378	36,408	9,102
9. COVERAGE CLASS 9	17,240	4,310	33,904	8,476	43,096	10,774	46,544	11,636	50,568	12,642
10. COVERAGE CLASS 10	23,444	5,861	46,108	11,527	58,612	14,653	63,300	15,825	68,772	17,193
11. NURSE/TECHNICIAN	148	37	288	72	364	91	392	98	428	107
12 PHYSIOTHERAPIST	292	73	572	143	728	182	784	196	852	213
13. PHYS ASST/NURSE PRAC	348	87	680	170	864	216	932	233	1,012	253

The Retroactive Date is the original date of your first MIEC policy.

6250 Claremont Avenue, Oakland, California 94618-1324
Telephone (415) 428-9411 / From outside California (800) 227-4527

MIEC **Medical Insurance Exchange of California**

ALASKA

Claims Made Professional Liability Premium Schedule

Effective June 1, 1988

Limits of Liability: 1,000,000 Each Claim / 3,000,000 Annual Aggregate

DOCTORS COVERAGE CLASSIFICATIONS	FIRST YEAR RATES RETROACTIVE DATES: 01/01/88 OR LATER		SECOND YEAR RATES RETROACTIVE DATES: 01/01/87 - 12/31/87		THIRD YEAR RATES RETROACTIVE DATES: 01/01/86 - 12/31/86		FOURTH YEAR RATES RETROACTIVE DATES: 01/01/85 - 12/31/85		FIFTH YEAR RATES RETROACTIVE DATES: 08/01/75 - 12/31/84	
	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY
1. COVERAGE CLASS 1	2,232	558	4,388	1,097	5,580	1,395	6,024	1,506	6,544	1,636
2. COVERAGE CLASS 2	2,840	710	5,584	1,396	7,100	1,775	7,668	1,917	8,332	2,083
3. COVERAGE CLASS 3	4,060	1,015	7,980	1,995	10,144	2,536	10,952	2,738	11,900	2,975
4. COVERAGE CLASS 4	4,668	1,167	9,176	2,294	11,664	2,916	12,596	3,149	13,684	3,421
5. COVERAGE CLASS 5	7,100	1,775	13,960	3,490	17,748	4,437	19,168	4,792	20,824	5,206
6. COVERAGE CLASS 6	7,912	1,978	15,556	3,889	19,776	4,944	21,356	5,339	23,204	5,801
7. COVERAGE CLASS 7	10,144	2,536	19,944	4,986	25,352	6,338	27,380	6,845	29,748	7,437
8. COVERAGE CLASS 8	14,604	3,651	28,720	7,180	36,508	9,127	39,428	9,857	42,832	10,708
9. COVERAGE CLASS 9	20,284	5,071	39,888	9,972	50,704	12,676	54,760	13,690	59,492	14,873
10. COVERAGE CLASS 10	27,584	6,896	54,244	13,561	68,956	17,239	74,472	18,618	80,904	20,226
11. NURSE/TECHNICIAN	172	43	336	84	428	107	464	116	500	125
12. PHYSIOTHERAPIST	344	86	672	168	856	214	924	231	1,000	250
13. PHYS ASST/NURSE PRAC	408	102	800	200	1,016	254	1,096	274	1,192	298

The Retroactive Date is the original date of your first MIEC policy.

6250 Claremont Avenue, Oakland, California 94618-1324
Telephone (415) 428-9411 / From outside California (800) 227-4527

MIEC

Medical Insurance Exchange of California

ALASKA

Claims Made Professional Liability Premium Schedule

Effective June 1, 1988

Limits of Liability: 2,000,000 Each Claim / 4,000,000 Annual Aggregate

DOCTORS COVERAGE CLASSIFICATIONS	FIRST YEAR RATES RETROACTIVE DATES: 01/01/88 OR LATER		SECOND YEAR RATES RETROACTIVE DATES: 01/01/87 - 12/31/87		THIRD YEAR RATES RETROACTIVE DATES: 01/01/86 - 12/31/86		FOURTH YEAR RATES RETROACTIVE DATES: 01/01/85 - 12/31/85		FIFTH YEAR RATES RETROACTIVE DATES: 08/01/75 - 12/31/84	
	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY
1. COVERAGE CLASS 1	2,968	742	5,836	1,459	7,420	1,855	8,012	2,003	8,704	2,176
2. COVERAGE CLASS 2	3,408	852	6,704	1,676	8,520	2,130	9,200	2,300	9,996	2,499
3. COVERAGE CLASS 3	4,868	1,217	9,576	2,394	12,168	3,042	13,144	3,286	14,280	3,570
4. COVERAGE CLASS 4	5,600	1,400	11,008	2,752	13,996	3,499	15,116	3,779	16,420	4,105
5. COVERAGE CLASS 5	8,520	2,130	16,752	4,188	21,296	5,324	23,000	5,750	24,988	6,247
6. COVERAGE CLASS 6	9,492	2,373	18,668	4,667	23,728	5,932	25,628	6,407	27,844	6,961
7. COVERAGE CLASS 7	12,676	3,169	24,928	6,232	31,688	7,922	34,224	8,556	37,184	9,296
8. COVERAGE CLASS 8	18,252	4,563	35,896	8,974	45,632	11,408	49,284	12,321	53,540	13,385
9. COVERAGE CLASS 9	26,364	6,591	51,852	12,963	65,912	16,478	71,184	17,796	77,336	19,334
10. COVERAGE CLASS 10	36,960	9,240	72,688	18,172	92,396	23,099	99,788	24,947	108,412	27,103
11. NURSE/TECHNICIAN	208	52	404	101	512	128	556	139	600	150
12. PHYSIOTHERAPIST	412	103	808	202	1,024	256	1,108	277	1,200	300
13. PHYS ASST/NURSE PRAC	488	122	960	240	1,220	305	1,316	329	1,428	357

The Retroactive Date is the original date of your first MIEC policy.

6250 Claremont Avenue, Oakland, California 94618-1324
Telephone (415) 428-9411 / From outside California (800) 227-4527

MIEC **Medical Insur. .ce Exchange of California**

ALASKA

Claims Made Professional Liability Premium Schedule

Effective June 1, 1988

Limits of Liability: 5,000,000 Each Claim / 5,000,000 Annual Aggregate

DOCTORS COVERAGE CLASSIFICATIONS	FIRST YEAR RATES RETROACTIVE DATES: 01/01/88 OR LATER		SECOND YEAR RATES RETROACTIVE DATES: 01/01/87 - 12/31/87		THIRD YEAR RATES RETROACTIVE DATES: 01/01/86 - 12/31/86		FOURTH YEAR RATES RETROACTIVE DATES: 01/01/85 - 12/31/85		FIFTH YEAR RATES RETROACTIVE DATES: 08/01/75 - 12/31/84	
	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY
1. COVERAGE CLASS 1	3,712	928	7,296	1,824	9,272	2,318	10,016	2,504	10,880	2,720
2. COVERAGE CLASS 2	4,260	1,065	8,376	2,094	10,648	2,662	11,500	2,875	12,496	3,124
3. COVERAGE CLASS 3	6,084	1,521	11,968	2,992	15,212	3,803	16,428	4,107	17,848	4,462
4. COVERAGE CLASS 4	7,000	1,750	13,760	3,440	17,492	4,373	18,892	4,723	20,524	5,131
5. COVERAGE CLASS 5	10,648	2,662	20,940	5,235	26,620	6,655	28,748	7,187	31,232	7,808
6. COVERAGE CLASS 6	11,864	2,966	23,336	5,834	29,660	7,415	32,036	8,009	34,804	8,701
7. COVERAGE CLASS 7	15,844	3,961	31,160	7,790	39,612	9,903	42,780	10,695	46,476	11,619
8. COVERAGE CLASS 8	22,816	5,704	44,872	11,218	57,040	14,260	61,604	15,401	66,924	16,731
9. COVERAGE CLASS 9	32,956	8,239	64,812	16,203	82,388	20,597	88,980	22,245	96,668	24,167
10. COVERAGE CLASS 10	46,200	11,550	90,856	22,714	115,496	28,874	124,736	31,184	135,516	33,879
11. NURSE/TECHNICIAN	256	64	504	126	640	160	692	173	752	188
12. PHYSIOTHERAPIST	512	128	1,008	252	1,280	320	1,384	346	1,500	375
13. PHYS ASST/NURSE PRAC	612	153	1,200	300	1,524	381	1,644	411	1,788	447

The Retroactive Date is the original date of your first MIEC policy.

6250 Claremont Avenue, Oakland, California 94618-1324
Telephone (415) 428-9411 / From outside California (800) 227 4527

MIEC **Medical Insurance Exchange of California**

ALASKA

Claims Made Professional Liability Premium Schedule Effective June 1, 1988

First Year New Doctor Rule Rates* Retroactive Date 1/1/88 or Later

DOCTORS COVERAGE CLASSIFICATIONS	LIMITS 1 500,000/1,500,000		LIMITS 2 1,000,000/3,000,000		LIMITS 3 2,000,000/4,000,000		LIMITS 4 5,000,000/5,000,000	
	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY
1. COVERAGE CLASS 1	475	118.75	558	139.50	742	185.50	928	232.00
2. COVERAGE CLASS 2	604	151.00	710	177.50	852	213.00	1,065	266.25
3. COVERAGE CLASS 3	862	215.50	1,015	253.75	1,217	304.25	1,521	380.25
4. COVERAGE CLASS 4	992	248.00	1,167	291.75	1,400	350.00	1,750	437.50
5. COVERAGE CLASS 5	1,509	377.25	1,775	443.75	2,130	532.50	2,662	665.50
6. COVERAGE CLASS 6	1,681	420.25	1,978	494.50	2,373	593.25	2,966	741.50
7. COVERAGE CLASS 7	2,155	538.75	2,536	634.00	3,169	792.25	3,961	990.25
8. COVERAGE CLASS 8	3,103	775.75	3,651	912.75	4,563	1,140.75	5,704	1,426.00
9. COVERAGE CLASS 9	4,310	1,077.50	5,071	1,267.75	6,591	1,647.75	8,239	2,059.75
10. COVERAGE CLASS 10	5,861	1,465.25	6,896	1,724.00	9,240	2,310.00	11,550	2,887.50

ALASKA
DATE PREPARED: MARCH 17,1988
PROCEDURE: NDPREM
USERID: MIECUWK

*These rates apply only to physicians entering the practice of medicine for the first time after completion of a residency, fellowship training or military service.

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Telephone (415) 428-9411 / From outside California (800) 227-4527

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P.O. Box Y, State Capitol
Juneau, Alaska 99811-3100
Mail Stop 3100
(907) 465-3991

April 18, 1989

MEMORANDUM

TO: Representative Peter Goll

ATTN: Hayden Kaden

FROM: Karen Oakley KO
Legislative Analyst

RE: **Medical Malpractice Premiums Paid by Alaska Doctors**
Research Request 89.297 (Supplemental Information)

You requested further information concerning medical malpractice insurance in Alaska. Specifically, you wanted to know how many private doctors are covered by the Medical Indemnity Corporation of Alaska (MICA) and how many are covered by other insurance companies or are without insurance. You also asked about reinsurance purchased by MICA.

According to Art Stanford, with the MICA underwriting department, MICA currently covers about 250 individual physicians, ten hospitals and ten to 12 "related health care facilities." The latter include clinics, such as the Alaska Kidney Center, which are staffed primarily by technicians.

There are just over 600 doctors in private practice in Alaska, thus, 40 percent of the private doctors in Alaska are insured with MICA. I was unable to obtain estimates of the number of doctors insured by each of the 22 other companies writing medical malpractice insurance in Alaska. In 1988, MICA had 48 percent of the medical malpractice market in Alaska, so these other companies together probably insure a similar number of doctors, leaving some 100 to 125 private doctors without insurance. This estimate of the number of uninsured doctors is consistent with the observations of Mary Pierce, executive director of MICA; she estimates that from 15 to 20 percent of Alaska's private doctors are currently "going bare".

Ms. Pierce provided information on reinsurance purchased by MICA. She indicated that MICA pays about $1.2 million for reinsurance annually. The primary reinsurer is Lloyd's of London, but a number of other companies, including at least one domestic hospital reinsurance company, sign on the policy. The MICA's retention (i.e., deductible portion) is $250,000 per claim, however, the retention is indexed and increases by about 10 percent per year between the time the claim is made and the time the claim is settled.

The MICA is an associate member of the Physicians' Insurance Association of America (PIAA). Because MICA is not a physician-owned company, MICA cannot be a full member of the PIAA. The MICA has broached the idea of putting together a reinsurance pool with the other members of PIAA, but the idea has not generated much interest. Compared with the other companies in the association, MICA is small, and the other companies have nothing to gain from joining with MICA. For further information on MICA's reinsurance situation, please contact Ms. Pierce at 563-3414.

I hope this information is useful. Please let me know if I can provide any further information.

page 27-29

How To

Tame the Insurance Industry Cycle

and

Make the Legal System More Efficient:

A Suggested Legislative Agenda for 1987

by

J. Robert Hunter, President
and
Jay Angoff, Counsel
National Insurance Consumer
Organization

Presented at the Annual
Meeting of the National
Conference of State
Legislatures
New Orleans, Louisiana
August 8, 1986

121 N. Payne Street
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to write elevator or boiler and machinery insurance. As a result, elevator and boiler accidents are today virtually unheard of. Insurers should spend more of their premium dollar on engineering, and insist that risks seeking hazardous waste insurance first obtain an "environmental audit" and take steps to minimize both the possibility that hazardous substances will be released and the extent of the harm should any such release occur. In that way insurers can both make money and encourage a safer environment.

A bill requiring municipalities which self-insure to set up risk management programs is attached as Exhibit M.

E. Allocate medical malpractice insurance costs more equitably

The problem with medical malpractice insurance is not its total cost -- $3.4 billion 17/ or 8/10 of 1% of the $425 billion 18/ spent on medical care in 1985 -- but its allocation.

The costs of the system are misallocated in four major ways. First, doctors in high-risk specialities pay for risks that should be shared by others. The medical profession may be viewed as a pyramid, with a base of thousands of general practitioners and an apex of relatively few high-risk specialists. The patient is pushed up the pyramid as his

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17/ Best's Insurance Management Reports, Insurance Premium Distribution - 1985, Release No. 22, July 21, 1986.

18/ The Washington Post, July 30, 1986, at 6.

case and its treatment become more complex. As the case gets more difficult and slight error more devastating, fewer and fewer doctors are asked to bear the cost.

For example, a man may go to see his family doctor because he has blood in his urine. The G.P. may send him to a urologist, the urologist may order x-rays, on the basis of those x-rays the urologist and radiologist may determine that the man has kidney cancer, a surgeon may partially remove the cancer, and a radiation oncologist may then treat the patient with radiation. Assume that the radiation oncologist radiates the wrong kidney and the patient dies. Under the current medical malpractice insurance system radiation oncologists must bear the cost of that mistake. Were it not for the diagnosis and treatment of many other doctors at different levels of the pyramid, however, the radiation oncologist would never have treated the patient. If doctors on lower levels of the pyramid bore a small portion of the cost of a mistake by doctors on higher levels -- on the rationale that all doctors benefit economically by treating patients on whom specialists undertake high-risk procedures -- the cost of malpractice insurance for high-risk specialists would go down. In addition, such a system would give all doctors a greater incentive to exercise due care in referring patients.

Second, doctors are broken down by insurance companies into too many categories, with too few doctors in some categories. In Wisconsin, for example, the few dozen

neurosurgeons in the state traditionally have constituted one category. Thus, if an insurance company pays a major claim against one neurosurgeon it must raise rates substantially to all neurosurgeons -- there are simply too few doctors in the category among whom to spread the risk. If insurers were required to put all doctors into three or four categories rather than the dozen or so they do today, an adequate spread of risk would exist in all categories. Doctors who are today paying exorbitant premiums would pay substantially less, while doctors paying very little today would find their premiums rising slightly. The statute recently enacted in Wisconsin requiring that doctors be grouped into no more than four categories is attached as Exhibit N1. A chart showing the effect on premiums of collapsing nine doctor classifications into three is attached as Exhibit N2.

Third, today doctors pay for malpractice that could more easily be borne by hospitals. Whenever a doctor makes a mistake, whether in making a diagnosis in his office or conducting a procedure in a hospital, the doctor pays. Charging hospitals for part of the cost of malpractice occurring in hospitals would have two positive effects. Because hospitals have a very large number of beds over which to spread risk, hospitals could bear the cost of malpractice occurring in hospitals better than doctors. And requiring hospitals to pay for malpractice occurring there would encourage them to make sure that the doctors to whom they grant privileges are competent.

Fourth, doctors, unlike drivers and homeowners, are not

not impose liability on the board of governors for payment of any part of a fund deficit.

(c) Collection and deposit of fees. ~~Annual fees~~ Fees under pars. (a) and (b) and future medical expense payments specified for the fund by a settlement, panel award or judgment entered into or rendered before the effective date of this act .... [revisor inserts date], shall be collected by the commissioner for deposit into the fund in a manner prescribed by the commissioner by rule.

(d) Rule not effective: fees. If the rule establishing fees under par. (b) does not take effect prior to June 2 of any fiscal year, the commissioner may elect to collect fees as established for the previous fiscal year. If the commissioner so elects and the rule subsequently takes effect, the balance for the fiscal year shall be collected or refunded or the remaining semiannual or quarterly instalment payments shall be adjusted except the commissioner may elect not to collect or refund or adjust for minimal amounts.

SECTION 63. 655.27 (3) (b) 2, (bg), (br) and (s) of the statutes are created to read:

655.27 (3) (b) 2. With respect to fees paid by medical and osteopathic physicians licensed under ch. 448, commencing with fees assessed for the fiscal year commencing July 1, 1986, the rule shall provide for ~~not more than~~ 4 payment classifications ~~based~~ upon the ~~amount~~ of surgery performed and the risk of diagnostic and therapeutic services provided or procedures performed.

(bg) Fee increase. 1. Every rule under par. (b) shall provide for an automatic increase in a health care provider's fees, except as provided in subd. 2, if the loss and expense experience of the fund and other sources with respect to the health care provider or an employe of the

EFFECT OF COLLAPSING FUND CLASSES

EXHIBIT N-2 (Misc.)

CLASS	MD's /CLASS	85-86 FEES	FEES/CLASS	NEW FEES	FEES/CLASS
1	2,698	1,809	4,880,682	2,500	6,755,000
2	952	3,620	3,446,240		
3	752	4,653	3,499,056	4,500	8,703,000
4	230	5,584	1,284,320		
5	772	9,308	7,185,776		
6	356	11,168	3,975,808		
7	330	13,030	4,299,900	9,500	14,221,500
8	4	904	3,616	(with Class 1)	
9	39	19,545	762,255		
	6,133		29,337,653		29,679,500

CHANGE TO THREE CLASSES OF PHYSICIANS

6-1641A
Ford
10/2/89

IN THE HOUSE

BY THE LABOR AND COMMERCE COMMITTEE

HOUSE BILL NO.

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to medical malpractice insurance rates."

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

* Section 1. AS 21.39.030(a) is amended to read:

(a) Rates shall be made in accordance with the following provisions:

(1) rates shall not be excessive, inadequate, or unfairly discriminatory;

(2) consideration shall be given to past and prospective loss experience inside and outside this state, to the conflagration and catastrophe hazards, to a reasonable margin for underwriting profit and contingencies, to dividends, savings, or unabsorbed premium deposits allowed or returned by insurers to their policyholders, members or subscribers, to past and prospective expenses both country-wide and those specially applicable to this state, and to all other relevant factors inside and outside this state;

(3) the systems of expense provisions included in the rates for use by an insurer or group of insurers may differ from those of other insurers or group of insurers to reflect the requirements of the operating methods of the insurer or group of insurers with respect to any kind of insurance, or with respect to a subdivision or combination of them [THEREOF] for which subdivision or combination separate expense provisions are applicable;

(4) risks may be grouped by classifications for the

establishment of rates and minimum premiums; classification rates may be modified to produce rates for individual risks in accordance with rating plans that [WHICH] establish standards for measuring variations in hazards or expense provisions, or both; the standards may measure any differences among risks that can be demonstrated to have a probable effect upon losses or expenses;

(5) in the case of fire insurance rates, consideration may be given to the experience of the fire insurance business during a period of not more than the most recent five-year period for which experience is available;

(6) when there is an established program to inspect new and existing dwellings and the program has been certified by the director as likely to reduce the incidence of fires in inspected dwellings, then in any rate plan used in this state, dwellings that [WHICH] have been found by the inspection to meet the standards established by the program shall have credits applied to the rate in amounts approved by the director;

(7) in the establishment of medical malpractice insurance rates and minimum premiums, risks may be grouped into not more than four classifications based on the amount of surgery performed and the risk of diagnostic and therapeutic services provided.