LEG. FINANCE - BILLS 1977 - 1978 941

SB 326

941

RECORDS CERTIFICATION

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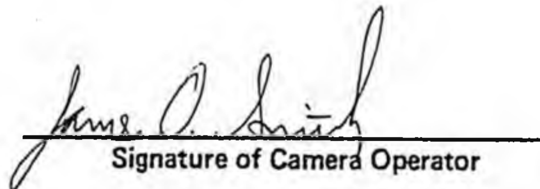

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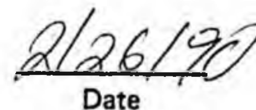


Date

02-519 (REV 8/78)

THE LEGISLATURE OF THE STATE OF ALASKA
TENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. SB 326
Title Relating to medical mapractice insurance coverage
Requested by ______ Date 4/19/77

II. FISCAL DETAIL
Agency Affected Commerce & Economic Development
Program Category Affected Protection
Budget Request Unit(s) Affected Division of Insurance

EXPENDITURES (Thousands of Dollars)

NONE

	FY 77	FY 78	FY 79	FY 80	FY 81	FY 82
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL						
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL						

FUNDING (Thousands of Dollars)

NONE

GENERAL FUND						
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

NONE

FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

NONE

IV. DATE April 19, 1977 PREPARED BY Richard L. Block
AGENCY Insurance
PHONE 465-2515

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33-001 (Rev. 10/76)

THE LEGISLATURE OF THE STATE OF ALASKA
TENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. SB 326
Title
Requested by Date

II. FISCAL DETAIL
Agency Affected
Program Category Affected
Budget Request Unit(s) Affected

EXPENDITURES (Thousands of Dollars)

	FY 77	FY 78	FY 79	FY 80	FY 81	FY 82
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL	(180,000)	180,000)	(180,000)	(180,000)	(180,000)	(180,000)
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.						
TOTAL	(180,000)	(180,000)	(180,000)	(180,000)	(180,000)	(180,000)

FUNDING (Thousands of Dollars)

	FY 77	FY 78	FY 79	FY 80	FY 81	FY 82
GENERAL FUND	(180,000	(180,000	(180,000	(180,000	(180,000	(180,000)
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

	FY 77	FY 78	FY 79	FY 80	FY 81	FY 82
FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

It is assumed the state will self-insure its malpractice exposure in much the same way it was doing prior to 1976 chapter 102. The $180,000 credit represents estimated premiums that would have been paid to MICA, not the difference between premiums and self-insured losses. These figures are estimates without the benefit of acturial information.

IV. DATE PREPARED BY
AGENCY
PHONE

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33 001 (Rev. 10/76)

THE LEGISLATURE OF THE STATE OF ALASKA
TENTH LEGISLATURE

FISCAL NOTE

I. REQUEST
Bill/Resolution No. CCSSB 326
Title
Requested by Date 5-24-77

II. FISCAL DETAIL
Agency Affected
Program Category Affected
Budget Request Unit(s) Affected

EXPENDITURES (Thousands of Dollars)

	FY 77	FY 78	FY 79	FY 80	FY 81	FY 82
100 PERSONAL SERVICES						
200 TRAVEL						
300 CONTRACTUAL		(130,000)	(180,000)	(180,000)	(180,000)	(180,000)
400 COMMODITIES						
500 EQUIPMENT						
600 LAND & STRUCTURES						
700 GRANTS, CLAIMS, ETC.		500,000	500,000	500,000	500,000	500,000
TOTAL		320,000	320,000	320,000	320,000	320,000

FUNDING (Thousands of Dollars)

	FY 77	FY 78	FY 79	FY 80	FY 81	FY 82
GENERAL FUND		320,000	320,000	320,000	320,000	320,000
FEDERAL FUNDS						
OTHER (Specify)						

POSITIONS

	FY 77	FY 78	FY 79	FY 80	FY 81	FY 82
FULL TIME						
PART TIME						
TEMPORARY						

III. ANALYSIS (See Fiscal Note Preparation Instructions, Section III)

Each year that MICA premiums are insufficient to pay the claims, additional funds from the General Fund would have to be advanced MICA. Due to the adverse selection feature, without protective measures as in SB 326 it is expected $500,000. will be needed each year. It is assumed the state will self-insure its malpractice exposure in much the same way it was doing prior to 1976 chapter 102. The $180,000. credit represents estimated premiums that would have been paid to MICA, not the difference between premiums and self-insured losses.. These figures are estimates without the benefit of actuarial information.

IV. DATE PREPARED BY
AGENCY
PHONE

Original: Legislative Finance
cc: Budget and Management
Prime Sponsor (First Legislator Named)

33 (01 (Rev 10/76)

STATE OF ALASKA
FISCAL IMPACT REPORT
MEDICAL MALPRACTICE INSURANCE
PROPOSALS

	Fiscal 77	Fiscal 79	Fiscal 80	Fiscal 81	Fiscal 82
SB 326					
- Administrative Impact Division of Insurance	0	0	0	0	0
① - Appropriation to Loan Fund (G.F.)	1500000	0	0	0	0
- Amounts required to be assigned to support MICA if premiums are insufficient to pay claims (G.F.)	0	0	500000	0	0
- Return to General Fund upon liquidation of MICA	0	0	0	0	(1000000) ②
② - Premium paid by state to MICA for malpractice ins	(180000)	(180000)	(180000)	(180000)	(1[illegible])
TOTAL	1320000	(150000)	320000	(180000)	(1180000)
CSSB 326 (State Reinsure)					
- Administrative Impact Division of Insurance	0	0	0	0	0
① - Appropriation to loan fund (G.F.)	1500000	0	0	0	0
- Amounts required to be advanced to support MICA if premiums are insufficient to pay claims (G.F.)	0	500000	500000	500000	500000
- Return to General Fund upon liquidation of MICA	0	0	0	0	0
- Premium paid by state to MICA for malpractice insurance	(180000)	(180000)	(180000)	(180000)	(180000)
TOTAL	1320000	320000	320000	320000	320000

① $1,500,000 was [illegible] by General Fund during FY 77 pursuant to A.S. [illegible](3). It is [illegible] that this [illegible] can be returned [illegible] the [illegible] amount. No [illegible] will need be [illegible] by the General Fund beyond the [illegible] appropriation unless the financial [illegible] of MICA becomes [illegible] [illegible] [illegible] to support a reinsurance [illegible].

② It is assumed that the state will [illegible] insure its malpractice exposure in MICA the same as [illegible] prior to 1976 [illegible]. These figures [illegible] premiums and [illegible] [illegible] [illegible] premiums [illegible] losses.

Prepared by [illegible] Division of Insurance [illegible] [illegible]

PROPOSED AMENDMENTS TO
SENATE BILL 326

* Section 1. PURPOSE. The purpose of this Act is to insure that no person suffers denial or revocation of licensure for any period of time for failure to procure insurance from the Medical Indemnity Corporation of Alaska or for failure to comply with any other requirement imposed by ch. 102 SLA 1976. This Act is for the further purpose of insuring that the coverage of occurrence policies issued by the Medical Indemnity Corporation of Alaska before the effective date of this Act continues to extend to claims arising out of occurrences before the effective date of this Act, but that (1) the Medical Indemnity Corporation of Alaska not be liable on an occurrence basis for any claims arising after the effective date of this Act; (2) persons who procured coverage from the Medical Indemnity Corporation of Alaska before the effective date of this Act neither be allowed to cancel the coverage procured nor evade the requirement of payment of premiums for that coverage; and (3) persons who did not procure retroactive coverage from the Medical Indemnity Corporation of Alaska by January 1, 1977 are not entitled to, nor may the Medical Indemnity Corporation of Alaska issue, that coverage.

* Sec. 3. AS 21.88.030 is amended by adding a new subsection to read:

(f) No governor, officer, or employee or former governor, officer, or employee of the corporation is liable for damages or other relief in any action by reason of his actions or inactions as a governor, officer, or employee of the corporation, or by reason of the actions or inactions of the corporation, its board of governors, officers or employees unless the person acts with actual knowledge that he was acting outside the scope of his authority, or at the time was acting for a purpose which he knew was not in the best interests of the corporation, or with respect to any criminal action he had actual knowledge or should have known his action was unlawful.

* Sec. 8. AS 21.88 is amended by adding a new section to read:

Sec. 21.88.055. TERMINATION. Upon termination of the affairs of the corporation the director shall be appointed receiver for the corporation by the court and the corporation shall be liquidated in accordance with ch. 78 of this title as if the corporation were a domestic insurer. When the director is appointed receiver, all officers and directors shall be discharged.

(c) Upon transfer of all of its assets and liabilities in accordance with this section and winding up its affairs, the corporation is dissolved and the corporation, its governors, officers and employees are relieved of all further liabilities for all of their obligations to the creditors and policyholders of the corporation.

* Sec. 12. AS 21.88.210(b)(1) is amended to read:

* Sec. 14. (a) The coverage obligations and duties of the insured under policies issued by the Medical Indemnity Corporation of Alaska before the effective date of this Act may not be breached without the consent of the Medical Indemnity Corporation of Alaska and the director of the division of insurance.

(b) All policies issued by the Medical Indemnity Corporation of Alaska before the effective date of this Act are terminated as of the effective date of this Act; however, if a person elects to purchase a policy for any term beginning after the effective date of this Act, a new policy may be issued that person provided that any new policies issued may only cover "covered claims", as defined in sec. 13 of this Act, which occur after the effective date of this Act.

* Sec. 15. ; AS 08.84.035;

* Sec. 18. Sections 3 and 15 of this Act are retroactive to June 28, 1976.

* Sec. 19. Sections 1, 2, 4 - 14 and 16 - 17 of this Act take effect July 1, 1977.

* Sec. 20. Sections 3 and 15 of this Act take effect immediately in accordance with AS 01.10.070(c).

* Sec. 11. AS 09.10.070 is amended by adding new subsections to read:

(b) Except as provided in (c) of this section, no person may bring a malpractice action based on negligence or wilful misconduct of

a health care provider unless commenced within two years of the act or omission. However, if the plaintiff first had knowledge of the act or omission complained of on a date within one year of the expiration of the period of the limitation, the time period during which an action may be brought is extended one year from that date, but in no event may an action be commenced later than three years from the date of the act or omission complained of.

(c) If the act or omission complained of occurred before the plaintiff attains the age of six years, an action brought under (b) of this section may be commenced at any time before the plaintiff attains the age of eight years, but may not be commenced after that date.

Mr. President: May 21, 1977

We are advised by Director Richard Block, of the Division of Insurance that if the State Affairs Committee Substitute for SB 326 is adopted, there will be a financial impact insofar as M.I.C.A. is concerned.

Although the attachments are far from exact, and admittedly so, we feel the legislation should be re-referred to the Finance Committee for additional research.

Director Block indicated a willingness to appear before the Finance Committee at its' request.

CHAIRMAN, SENATE RULES COMMITTEE

Introduced: 4/18/77
Referred: State Affairs

BY COLLETTA, KERTTULA, RODEY,
AND HUBER BY REQUEST

IN THE SENATE

SENATE BILL NO. 326

IN THE LEGISLATURE OF THE STATE OF ALASKA

TENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act relating to medical malpractice insurance coverage; and providing for an effective date."

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

* Section 1. AS 21.88.030(a)(1) is repealed and re-enacted to read:

(1) four physicians licensed in the state and engaged in private practice in the state; no more than two of the physicians shall practice or live in a municipality having a population of more than 100,000;

* Sec. 2. AS 21.88.050(a)(1) is amended to read:

(1) in the form approved by the director, issue to all physicians and hospitals who pay the premiums for it a contract or contracts indemnifying physicians and hospitals and their employees who are health care providers against loss by reason of liability for covered claims for an act or omission in the delivery of professional health care in this state [PROFESSIONAL SERVICES RENDERED IN THE STATE ON AN OCCURRENCE BASIS], and agreeing to tender on behalf of the physicians and hospitals and their employees who are health care providers a defense to [IN] a covered claim in a proceeding brought under AS 09.55.530 - 09.55.560; the limit of liability issued to physicians shall be $200,000 per occurrence and $600,000 aggregate liability per year, and the limit of liability provided in contracts issued to hospitals shall be $200,000 per occurrence and an annual aggregate liability of $1,000,000 plus an additional $20,000 per bed for each bed over 50 [SHALL BE NO LESS THAN THE MINIMUM LIABILITY COVERAGE REQUIREMENTS TO BE MAINTAINED UNDER

1 AS 08.64.215 AND AS 18.20.045]; the contract shall cover the defense
2 against but need not indemnify a covered claim for punitive damages;
3 at the option of the physician or hospital and for an additional pre-
4 mium the contract may cover claims against the physician or hospital
5 that arise out of professional services performed by the physician or
6 hospital for any period after December 31, 1974 except that coverage
7 will not be provided for a claim already filed or of which the physician
8 or hospital had or reasonably should have had notice at the time the
9 retroactive insurance was purchased;
10 * Sec. 3. AS 21.88.050(a) is amended by adding a new paragraph to read:
11 (8) cease operation and terminate its affairs if, for two
12 consecutive annual periods, the corporation posts written premium in
13 amounts less than 50 per cent or if, for one annual period, it posts
14 written premium in an amount less than 35 per cent of the total written
15 premium of all medical malpractice insurance for risks of physicians and
16 hospitals in Alaska; in any event, the corporation shall cease operation
17 and terminate its affairs not later than June 30, 1979.
18 * Sec. 4. AS 21.88.050(b)(2) is repealed and re-enacted to read:
19 (2) negotiate for and procure reinsurance from private
20 casualty insurers or reinsurers for any and all liability incurred by
21 contracts issued by it;
22 * Sec. 5. AS 21.88.050(b) is amended by adding a new paragraph to read:
23 (10) in a form approved by the director and for an additional
24 premium determined under sec. 80 of this chapter, issue endorsements
25 which provide indemnity for claims not yet reported which arise out of
26 professional services rendered during a period of continuous coverage
27 under the originally issued contract, to physicians and hospitals who
28 pay the premium for it and who are terminating their original covered
29 claims contract with the corporation for a period of not less than one

year.

* Sec. 6. AS 21.88.080(4), (5) and (14) are amended to read:

(4) rates may not be excessive; rates are excessive if, after a period of time and with respect to an amount of gross premium which are actuarially credible, the premiums exceed losses incurred by the corporation, including losses paid, reserves for covered claims reported and unpaid, reserves for covered claims incurred during the policy period and not reported, [PROVIDED THAT RESERVES FOR CLAIMS INCURRED DURING THE POLICY PERIOD AND REASONABLY EXPECTED TO BE REPORTED AFTER THREE YEARS AFTER THE INCIDENT MAY BE INCLUDED ON A DIFFERENT BASIS DUE TO THE ADDITIONAL FINANCIAL FLEXIBILITY PROVIDED BY THE CORPORATION,] and reasonable expenses for the operation of the corporation;

(5) rates shall not be inadequate; rates are inadequate if, based on available actuarial data, the premiums to be paid by the health care providers are or may reasonably be expected to be insufficient to pay for losses incurred by the corporation, including covered claims paid, reserves for covered claims reported and unpaid, reserves for covered claims incurred during the policy period and not reported, [PROVIDED THAT RESERVES FOR CLAIMS INCURRED DURING THE POLICY PERIOD AND REASONABLY EXPECTED TO BE REPORTED AFTER THREE YEARS AFTER THE INCIDENT MAY BE INCLUDED ON A DIFFERENT BASIS DUE TO THE ADDITIONAL FINANCIAL FLEXIBILITY PROVIDED BY THE CORPORATION,] and reasonable expenses for the operation of the corporation;

(14) [IF THE APPROACH UNDER SEC. 50(a)(3)(B) OF THIS CHAPTER IS ADOPTED BY THE CORPORATION,] provisions may [SHALL] be made for underwriting profit at a reasonable level for any reinsurer [, EXCEPT THAT IF THE CORPORATION IS UNABLE TO PURCHASE ALL ITS REINSURANCE FROM THE PRIVATE MARKET AND MUST PURCHASE A PORTION FROM THE ASSOCIATION, NO PROVISION FOR UNDERWRITING PROFIT FOR PRIVATE CARRIERS MAY BE MADE].

1 * Sec. 7. AS 21.88.080 is amended by adding new paragraphs to read:
2 (15) if the collected premiums of the corporation for any
3 given year are less than the incurred claims, claim expense, underwriting
4 expense, reserves for that year and provision for repayment of any
5 loans, the corporation shall, subject to the prior approval of the
6 director, levy an assessment upon the insureds who held policies during
7 that year; the assessment, which may be made in periodic installments,
8 shall be made within three years and may not exceed 150 per cent of the
9 physician's premium for that year; the termination of any policy does
10 not relieve the insured of contingent liability for his proportionate
11 share of the obligations to the corporation which accrued while the
12 policy was in force;
13 (16) if the collected premiums of the corporation for any
14 given year exceed its incurred claim expense, underwriting expense,
15 reserves for that year and provision for repayment of any loan, the
16 corporation may, subject to the prior approval of the director, appor-
17 tion and pay or credit its insureds who held policies during that year;
18 a payment or credit shall be proportionate to the insured's earned
19 premium for that year.
20 * Sec. 8. AS 21.88 is amended by adding a new section to read:
21 Sec. 21.88.095. TRANSFER OF CORPORATE ASSETS AND LIABILITIES. (a)
22 The corporation shall transfer its assets and liabilities to a company
23 which meets all of the following conditions:
24 (1) the company possesses a valid certificate of authority to
25 transact business in the state; in evaluating the capital and surplus of
26 the company for qualification for a certificate of authority, the value
27 of the assets and liabilities transferred by the corporation may not be
28 considered;
29 (2) the company pays to the corporation the full value of any

surplus in the corporation not represented by any unrepaid proceeds of loans by the loan fund to the corporation;

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

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

(A) to assume the obligations;

(B) that, if at any time the company writes less than the premium levels provided in sec. 50(a)(8) of this chapter, the loan provisions shall be modified to provide a scheduled amortization repayment of the principal over a period not to exceed 10 years; and

(C) that the provision for repayment provided in sec. 210(b)(1) of this chapter shall be modified to provide for annual installments of at least 25 per cent of the excess of premium and investment income collected over the total of claims, reserves and expenses on the medical malpractice book of business or 25 per cent of the excess of premiums and investment income collected over the total of claims, reserves and expenses on the corporation's total book of business, whichever is greater.

(b) If the company to which the assets and liabilities of the corporation are transferred in the manner provided in (a) of this section is an Alaska domestic stock company and continues to write premiums in excess of the levels provided in sec. 50(a)(8) of this chapter, it shall enjoy the benefit of the following provisions:

(1) the company is entitled to carry forward and offset against its premium tax obligation the amount by which the aggregate

1 claims paid on reinsurance assumed under (a)(3) of this section exceeds
2 aggregate reserves on the same business; and
3 (2) the obligation to repay to the loan fund loans assumed
4 by the company at the time of transfer of the assets and liabilities
5 of the corporation need not be shown as a liability on the books of the
6 corporation.
7 * Sec. 9. AS 21.88.210(b)(1) is amended to read:
8 (1) to provide surplus in respect to policyholders which may
9 not exceed a total of $3,000,000 outstanding at any time; these obliga-
10 tions shall be subordinated to all other obligations of the corporation;
11 loans made under this paragraph shall be repaid to the fund in annual
12 installments of at least 25 per cent of the excess of premiums collected
13 over the total of claims, reserves, expenses, and assessments made by
14 the association, if any; interest shall be paid on the outstanding
15 balance at a rate equal to <u>one</u> [FOUR] percentage <u>point</u> [POINTS] above
16 the annual rate charged member banks for advances by the 12th Federal
17 Reserve District;
18 * Sec. 10. AS 21.88.900 is amended by adding new paragraphs to read:
19 (16) "continuous coverage" means one or more successive
20 policy periods which is uninterrupted by cancellation or failure to re-
21 new for any reason;
22 (17) "covered claim" means a claim by an injured patient re-
23 ported to the corporation during the period of continuous coverage by
24 the corporation of the insured health care provider for an act or omis-
25 sion in the delivery of health care services during the same period of
26 continuous coverage.
27 * Sec. 11. AS 09.10.070 is amended by adding new subsections to read:
28 (b) Except as provided in (c) of this section, no person may
29 bring a malpractice action based on negligence or wilful misconduct of

a health care provider unless commenced within two years of the act or omission. However, if the plaintiff first had knowledge of the act or omission complained of on a date within one year of the expiration of the period of the limitation, the time period during which an action may be brought is extended one year from that date, but in no event may an action be commenced later than three years from the date of the act or omission complained of.

(c) If the act or omission complained of occurred before the plaintiff attains the age of six years, an action brought under (b) of this section may be commenced at any time before the plaintiff attains the age of eight years, but may not be commenced after that date.

* Sec. 12. The following are repealed: AS 08.20.115; AS 08.32.015; AS 08.36.115; AS 08.64.215; AS 08.68.165; AS 08.71.085; AS 08.72.115; AS 08.80.115; AS 08.86.125; AS 18.20.045; AS 21.18.090(5) and (6); AS 21.88.050(a)(2), (3) and (7), 21.88.080(1), 21.88.110 - 21.88.180, and 21.88.900(1).

* Sec. 13. AS 21.88.210(b)(2) and (d) are repealed.

* Sec. 14. Sections 1 - 12 of this Act take effect July 1, 1977. Section 13 of this Act takes effect immediately upon the adoption of a bill appropriating the sum of $1,500,000 to the medical malpractice liability revolving loan fund established in AS 21.88.210(a).

Offered: 5/19/77
Referred: Finance

1 IN THE SENATE BY THE STATE AFFAIRS COMMITTEE

2 CS FOR SENATE BILL NO. 326

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 TENTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act eliminating requirement that health care pro-
7 viders purchase medical malpractice insurance from the
8 Medical Indemnity Corporation of Alaska."

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

10 * Section 1. AS 08.20.115, AS 08.32.015, AS 08.36.115, AS 08.64.215,
11 AS 08.68.165, AS 08.71.085, AS 08.72.115, AS 08.80.115, AS 08.84.035, AS
12 08.86.125; AS 18.20.045; and AS 21.88.050(a)(2) are repealed.

13 * Sec. 2. AS 21.88.050(a)(1) is amended to read:

14 (1) in the form approved by the director, issue to all health
15 care providers [PHYSICIANS AND HOSPITALS] who pay the premiums for it a
16 contract or contracts indemnifying health care providers [PHYSICIANS AND
17 HOSPITALS] and their employees who are health care providers against
18 loss by reason of liability for professional services rendered in the
19 state on an occurrence basis, and agreeing to tender on behalf of the
20 health care providers [PHYSICIANS AND HOSPITALS] and their employees who
21 are health care providers a defense in a proceeding brought under
22 AS 09.55.530 - 09.55.560; the limit of liability provided in contracts
23 issued to doctors and hospitals shall be no less than the minimum
24 liability coverage requirements to be maintained under AS 08.64.215 and
25 AS 18.20.045; the contract shall cover the defense against but need not
26 indemnify a claim for punitive damages; at the option of a [THE] physi-
27 cian or hospital and for an additional premium the contract may cover
28 claims against a [THE] physician or hospital that arise out of profes-
29 sional services performed by the physician or hospital for any period

1 after December 31, 1974 except that coverage will not be provided for a
2 claim already filed or of which the physician or hospital had or rea-
3 sonably should have had notice at the time the retroactive insurance was
4 purchased;

5 * Sec. 3. AS 21.88.150(a)(1) is amended to read:

6 (1) provide reinsurance to the corporation covering contracts
7 issued by the corporation for that portion of the liability incurred by
8 the corporation which cannot be reinsured through private casualty in-
9 surers or reinsurers, indemnifying <u>health care providers</u> [PHYSICIANS AND
10 HOSPITALS,] and their employees who are health care providers, and other
11 persons insured by the corporation against loss by reason of liability
12 for professional services and agreeing to tender on behalf of the
13 insureds a defense in an action brought under AS 09.55.530 - 09.55.560;

14 * Sec. 4. Section 48, ch. 102, SLA 1976 is amended to read:

15 Sec. 48. AS 01.10.030 applies to this Act except that if any por-
16 tion of AS 21.88.110 - 21.88.180 is held invalid all of AS 21.88.110 -
17 21.88.180 shall be void and the Medical Indemnity Corporation of Alaska
18 shall assume all duties and liabilities incurred by the Health Care
19 Providers Joint Underwriting Association before the declaration of in-
20 validity; [AND EXCEPT THAT IF THE REQUIREMENT THAT HEALTH CARE PROVIDERS
21 PURCHASE MEDICAL MALPRACTICE INSURANCE FROM THE MEDICAL INDEMNITY
22 CORPORATION OF ALASKA IS FOUND TO BE INVALID, SECS. 41, 42, 43, AND 44
23 OF THIS ACT ARE VOID;] however, the Medical Indemnity Corporation of
24 Alaska and the Health Care Providers Joint Underwriting Association
25 shall continue to discharge and assess to pay claims incurred before the
26 declaration of invalidity.
27
28
29

#

STATE OF ALASKA

JAY S. HAMMOND, GOVERNOR

DEPARTMENT OF COMMERCE &
ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE / POUCH D — JUNEAU 99811

March 14, 1977

To All Senators and Representatives
Alaska State Legislature

Enclosed is a copy of the first interim report of the Director of the Division of Insurance concerning the establishment and operation of the Medical Indemnity Corporation of Alaska.

Attached to the report you will find, as exhibits, a copy of the law, plan of operation, a copy of the order issued by the Director of Insurance disapproving the original rate filing, and a copy of the finally approved rate filings.

Should you desire any further information, I would be happy to have you call upon us.

Yours cordially,

Richard L. Block
Director

RLB:cjwl/3

Enclosures

Interim Report
of the
Director of The Division of Insurance
of the
Medical Indemnity Corporation of Alaska

Chapter 102 Alaska Statutes 1976.

On May 28, 1976 the Governor signed into law FCCSSCS CS HB 574 - An act of the Legislature relating to health care, changing the Alaska Supreme Court's Rules of Civil Procedures, and providing for an effective date.

That is the legislation which made substantial changes to the remedies and rights of persons injured by reason of medical malpractice; which established new procedures and authorities in the medical licensing board governing the activities of physicians and which established the Medical Indemnity Corporation of Alaska; a facility which has the obligation of assuring immediate availability of minimum limits of medical malpractice insurance to all licensed physicians in the State.

Much of the legislation was recognized at the time as having little or no immediate effect; that is, changing the definition of medical negligence, changing the measure of liability of establishing a requirement that medical malpractice litigation go to an advisory panel before going before the jury, would not really have a telling effect until there was a medical malpractice case filed and taken to trial under the new procedures and new rules. Obviously, it could take quite some time before the effectiveness of these provisions would be tested.

By the same token, the provisions establishing new authorities in the licensing board and provisions enhancing the ability of the physicians to self-discipline their profession would also require a substantial period of time before the effectiveness of this legislation could be measured.

Accordingly, all involved, The Administration, The Legislature, and the physicians, must continue to rely on experience, intuition, and the advice of others in assuming that the legislative package adopted last year will truly have a beneficial affect on the long-term cost of bodily injury reparations resulting from medical malpractice.

The only significant segment of Chapter 102 which has been put to immediate test has been the implementation of the Medical Indemnity Corporation of Alaska.

Shortly after the adoption of the act, the Division of Insurance set about to implement and bring into existence the corporation which the Legislature required to be formed to provide insurance to the physicians and hospitals.

As of this date, It can be reported that the Medical Indemnity Corporation of Alaska has been formed; has been capitalized; has entered into contracts for the management of its affairs; has formulated policy; forms, rates, and rating plans; developed an actuarial projection of its financial condition; established procedures for the handling of claims; has opened its doors to receive applications for insurance and has, in fact, bound over 180 medical malpractice risks.

It might be appropriate to end the report at this point indicating that the wish of the Legislature has been carried out. To do so, however, would overlook and fail to recognize the substantial amount of effort that was put forward to make the Medical Indemnity Corporation the functioning organization that it is and it is well for the Legislature to have some insight into the process by which its legislative fiat was turned into actual accomplishment.

Preliminary Work

In March or April of 1976, the Division of Insurance began to assume that the medical malpractice law would be enacted and that it would contain provisions for the establishment of some state operated insurance mechanism and that there would be the necessity of calculating some premiums and projecting losses which would flow through this entity.

Accordingly, the Division of Insurance retained the firm of Milliman and Robertson, an actuarial consulting firm, with the understanding that if the law were adopted the Medical Indemnity Corporation of Alaska would fund all of their work and if the law did not pass or if the Board of Medical Indemnity Corporation of Alaska chose not to retain the firm of Milliman and Robertson, then the Division of Insurance would pay for the services performed through the date of that determination.

Milliman and Robertson began doing actuarial work based upon statistics provided by the Division of Insurance, which were essentally the same statistics which were presented to the Medical Malpractice Commission in 1975, plus additional information requested by Milliman and Robertson which they regarded as necessary to complete the project.

Milliman and Robertson

Milliman and Robertson is a national consulting actuarial firm with headquarters in Seattle, Washington. It has developed over the years a reputation for doing exceptionally fine work, particularly with respect to property and casualty insurance questions. Although Milliman and Robertson have several offices throughout the United States, the office in Pasadena, California is the one in which most of the actuaries are employed who have particular familiarity with property and casuality issues and, more particularly, with medical malpractice programs.

The Director of the Division Insurance selected Milliman and Robertson to begin the initial work because that firm was known to have had a substantial amount of experience in doing actuarial work for other lines of insurance sold in the State of Alaska and also known to have done a substantial amount of work in medical malpractice programs in other states.

The Medical Indemnity Corporation of Alaska was not obligated to continue the work of Milliman and Robertson, however, it elected to do so and I believe primarily because of the quality of work done to the date of its first presentation to the board.

Selection of the Board

After the adoption of the law, the most critical first step was the selection of persons to serve on the Board of Governors.

As required by law, the Governors were all appointed by the Governor of the State. However, as you can imagine, the Governor relied upon recommendations from the Administration and it is of interest to know some of the criteria that went into the selection of those who were originally appointed to the board and who now serve on the Board.

The Statute requires that there be two persons selected from the insurance industry, two physicians, one of whom must be from a clinic of six or more physicians, one person representing the hospitals and two members not connected with the insurance or the health care industries.

It was felt that the Board should be composed of a balance of talents, as well as good geographic representation throughout the State of Alaska.

The persons ultimately selected as the original Governors were: Dr. Rodman Wilson, Dr. Robert Taylor, Mr. Donald Sharp, Mr. David Frazier, Mr. Victor Dirksen, Mr. Charles Flynn, and Mr. William Brock.

Dr. Wilson is an Anchorage physician practicing at the Providence Professional Complex. He is an internist and thus represents a large segment of physicians whose practice does not include surgery or the types of practice which traditionally are recognized as high-risk procedures. Dr. Wilson probably is the most knowledgeable physician in the State concerning the medical malpractice insurance dilemma, having served as a past president of the Alaska State Medical Society, a past chairman of the Alaska State Medical Society's Legislative Committee, and having worked deligently in the legislative programs predating the Medical Malpractice Insurance Commission. Dr. Wilson served on the Medical Malpractice Insurance Commission and was one of the leading lobbyists representing physicians in 1976 when Chapter 102 was being considered.

Dr. Robert Taylor, on the other hand, is a urological surgeon from Fairbanks and can be said to represent that segment of physicians whose practice is essentially in the high-risk categories. Dr.Taylor is employed with the Fairbanks Medical Surgical Clinic and thus meets the criteria of the statute that one of the physicians be from a clinic of six or more. Dr. Taylor is a physician who played little or no role in the development of the legislation either during the commission days or during the period that the legislation was being considered by the Legislature.

Mr. Donald Sharp was the Vice-President of Industrial Indemnity of Alaska and had at the time of his appointment 13 years of insurance experience with that company working in claims, underwriting, marketing,

and finally as Executive Manager. Don Sharp was one of the insurance representatives on the Medical Malpractice Insurance Commission and was thus quite familiar with the background of the law.

Mr. David Frazier is Marketing Manager for Blue Cross Washington/Alaska and has been with that company for over six years. Blue Cross representation was regarded as a significant contribution because of Blue Cross' unique function of coordinating insurance benefits for hospitals. Mr. Frazier brings to the board a unique blend of background in both insurance principles and knowledge of hospital practices and medical care. He also brought to the board fresh new approaches to some of the concerns which the board would face, having not served on the commission or having dealt with the legislative process at the time the law was being considered.

Mr. Victor Dirksen is the Administrator of the Bartlett Memorial Hospital and at the time of his appointment was the President of the Alaska State Hospital Association. Mr. Dirksen has a number of years of experience in hospital administration.

Mr. Charles Flynn is an attorney from Anchorage practicing with the firm of Burr, Pease & Kurtz and engages in a substantial amount of litigation in the defense of liability cases. Mr. Flynn served on the Medical Malpractice Insurance Commission and brings to the board a strong background in the legal aspects of the corporate affairs of MICA as well as a good understanding of the concerns that the board would have concerning the defense of medical malpractice insurance claims.

Finally, Mr. William Brock, who is President of the B.M. Behrends bank of Juneau. Mr. Brock also brought to the board a fresh new approach to the medical malpractice issue, having not served on the commission nor having been involved in the legislative process. Mr. Brock's principal contribution was expected to be his background in business management, finance, and investments. However, he has also brought a great deal of leadership to the board.

In its original constitution the board included three persons who had served on the Medical Malpractice Insurance Commission and four who had not. The board consists of two persons from Southeastern Alaska, one person from Fairbanks, and four persons from the Anchorage area. The board includes a physician representing a clinic and representing the more hazardous surgical classifications and one physician representing the sole practitioner or private practitioner engaged in family practice and in the lower classifications of physician practice.

The board includes an attorney familiar with insurance defense, a banker familiar with investment, finance, and business management, two persons, being the hospital administrator and the representative of Blue Cross, who are familiar with hospital practice and the relationship between insurance mechanisms and health care mechanisms.

Thus, the board was selected and appointed by June 10, 1976.

Since the board was originally constituted, there have been two resignations. First, Dr. Rodman Wilson resigned in December. Dr. Wilson was replaced by Dr. James Baldouf, a physician practicing in private practice in Anchorage. On the occasion of selecting a replacement for

Dr. Wilson, since the board was already constituted and MICA was functioning, more time could be taken in the selection of a replacement physician. At or about this time there was considerable expression of discontent among physicians because they did not play a broader role in the selection of the physician representatives. Accordingly, the Governor wrote to Dr. Whaley, the then President of the Alaska State Medical Society, inviting the society to submit five or more names of physicians that they regarded as representative, from which the Governor could select one. Dr. Baldouf was included in the list of names submitted by Dr. Whaley.

Mr. Don Sharp, of Industrial Indemnity, resigned from Industrial Indemnity and has moved to engage in a somewhat different line of business in the State of California.

He was replaced by Mr. Gregg Brown, who is the Claims Manager for Industrial Indemnity of Alaska, and has been in the insurance industry for many years.

Meetings of the Board of Governors

The Board of Governors held its first meeting June 16, which was actually prior to June 28, the effective date of the law establishing the Medical Indemnity Corporation of Alaska. It was recognized that there was a substantial amount of work that had to be done and the earliest possible meeting of the directors was indicated.

Meetings were held frequently after that date and, in fact, there were two unofficial meetings prior to June 28 and ten official meetings between June 28 and today. No meeting has run less than one full day and most meetings have run two full days. In addition, the board has conducted a substantial amount of business through the meeting of several of its committees.

The Director of Insurance conducted the first several meetings of the board as Chairman pro tem until a plan of operation and a means of electing officers had been formally established.

From the minutes of the meetings, it may be seen that the important business of establishing rates, policy forms, capitalization, and mechanics for operation of the company were undertaken immediately and were the subject of every meeting until rates and forms were finally approved. At the same time, procedural matters were discussed.

Plan of Operation

A special committee was appointed to draft a plan of operation in accorance with the requirements of the statute. A copy of the Plan of Operation is included in the blue pamphlet entitled, "State of Alaska Medical Malpractice Insurance Law," which is attached as an exhibit to this report.

The plan establishes the procedures for election of officers and establishes the duties of the officers of the board and officers of the corporation. It establishes certain required committees and lays out the orderly means of conducting the business of the board and the business of the corporation. In the seven months of its operation, the plan has proved to be a very workable document and has allowed for an orderly conduct of all the business of the corporation.

Some key features of the plan should be noted:

The plans call for quarterly meetings of the Board of Governors, however, it was recognized that a substantial amount of important business may require attention between quarterly meetings and an executive committee is authorized to conduct certain business. The executive committee consists of the three elected officers of the Board of Governors; the Chairman, the Vice-chairman and the Second Vice-chairman.

The officers are elected by secret ballot and the plan provides that there cannot be more than one person elected to office from each of the appointment categories, that is to say, there may be only one physician, one insurance executive, and only one person from the public appointees essentially a balance of representation.

It should also be noted that the plan established other committees as follows:

1. An Audit Committee - consisting of at least three Governors not on the executive committee whose function is is to supervise the auditing of the corporate affairs.

2. An Underwriting Committee - consisting of at least one insurance professional and at least one physician whose function it is to review and make recommendations with respect to policy forms, coverage, rates, rating plans, and underwriting criteria.

3. A Finance and Investment Committee

4. A Legislative Committee

5. Such other special committees as the Board of Governors deem necessary.

The plan requires compliance with a conflict of interest procedure and the conflict of interest procedure is set forth with particularity in the plan..

The plan also provides for a balance between confidentiality of the affairs of the MICA and an opportunity for interested persons to be heard before the Board of Governors.

It was felt initially that the matters discussed by the board were sensitive in nature and very often would deal in highly confidential affairs of the physicians practicing in the State. This would be true particularily with respect to claim files and individual underwriting considerations. Even when discussing general matters, such as rating and rating plans, a discussion of physician income and revenues and other matters which the board felt were more properly discussed *in camera* would be continually the subject of concern of the board. Accordingly, it was felt that the meetings of the board should be held in Executive Session. At the same time it was recognized that persons not on the board may have a particular matter

that they wish the board to consider or a position to advocate with respect to a matter currently on the board's agenda. Therefore, a procedure was established in the plan which required the board to hear any person who served notice of their desire to attend a board meeting to speak on any matter.

It should be pointed out, of course, all of the significant action taken by the board of the MICA, particularly as it relates to major contracts, reinsurance agreements, rates, rating plans, and forms, are subject to the approval of the Division of Insurance and all proceedings of the Division of Insurance in which such matters are considered are public record and subject to public hearing procedures, as provided in the insurance code. Thus, no significant action by the board can be taken without adequate public exposure and opportunity for a public hearing.

At the last meeting of the Board of Governors, the Board proposed an amendment to the plan of operation authorizing physicians to attend board meetings at any and all times, except where matters pertaining to an individual physician are being discussed.

The the first meeting after the adoption of the Plan of Operation officers were elected a follows:

Mr. William Brock, Chairman
Mr. David Frazier, First Vice-Chairman
Dr. Robert Taylor, Second Vice-Chairman

Administration and Management

The board considered the means by which the affairs of MICA would be conducted

There was and still is open to the MICA several options as to how its affairs should be managed.

First, of course, the Medical Indemnity Corporation of Alaska could hire employees for the purpose of issuing the policies, collecting the premiums, administering the claims, performing the statistical and accounting functions, and in other ways carrying out the administrative responsibilities given the corporation.

A second alternative is to enter into a management contract with a company experienced in handling insurance company matters to perform all of those functions for the corporation.

A third option is to contract for certain specific functions and perform other functions with other contractors or with hired employees.

The minutes will reflect that the board considered all of these options carefully and concluded that, for the initial years of its activity, the Medical Indemnity Corporation of Alaska would be better advantaged by hiring a corportation experienced in these matters to handle all of the management and administration of the company subject to the direction and guidance of the Board of Governors and its committees.

One of the principal advantages of such a contract appeared to be that services could be rendered immediately, taking advantage of the resources of the management company without the necessity of a heavy

investment during the formative period of the MICA, compensating the manager as a percentage of premiums as the premiums were paid in.

Accordingly, a call for bids went to numerous insurance carriers and other entities that might have some particular expertise in managing a medical malpractice program.

At the request of the Board of Governors, an invitation to submit a proposal was issued to the St. Paul Fire and Marine Insurance Company, a company known to be heavily involved in medical malpractice insurance programs in other states; to the Hartford Insurance Companies, which is a large writer of medical malpractice insurance in other states; to the Travelers Insurance Companies, which like the Harford, underwrites a substantial amount of medical malpractice insurance; to the Industrial Indemnity Company, which although it does not write medical malpractice insurance does have a substantial and well respected insurance management facility in the State of Alaska; American Health Systems, Inc., which is a company known to the consulting actuaries selected by MICA as having expertise in establishing medical malpractice programs; the American Mutual Insurance Company, which writes medical malpractice liability insurance in selected areas; the Continental Insurance Company, which is currently phasing out of medical malpractice insurance, but was responsible for the writing of a substantial portion of the medical malpractice insurance in Alaska up to the time of the so called crisis, and the CNA Insurance Group, which currently is writing a major share of medical malpractice insurance in this State.

In addition, Marsh and McClennan, an insurance brokerage firm which had worked for about two years with the Alaska State medical Society in designing an insurance program, and Alaska Pacific Assurance Company, which has a highly respected management facility in the State of Alaska, were all invited to submit proposals.

Three requests to submit a proposal were received. American Health Systems, Inc., indicated an initial interest, however, they finally elected not to come to Alaska to make a proposal. Marsh and McClennan did accept the invitation to make a proposal and, in fact, appeared before the Board of Governors with a proposal that they be responsible for the management of Medical Indemnity Corporation of Alaska, and that they incorporate its management with that of a California program and other medical malpractice insurance programs they now manage in the Lower '48.

Finally, Alaska Pacific Assurance Company made a proposal that they manage the company. The essence of their proposal, and the contract which ultimately was negotiated, call for their performing all functions for MICA and charging MICA actual cost based on time records maintained by the ALPAC employees performing the services, however, MICA would pay for these services as premiums are earned. In addition Alaska Pacific Assurance Company would be paid a profit factor which under its initial proposal amounted to two percent (2%) of earned premiums. The contract would provide that despite the time charges made to MICA there would be maximum amounts above which the cost would not exceed.

Although the contract has gone through substantial negotiation, the contract has not been signed and within the last week or so, Alaska

Pacific Assurance Company, recognizing the substantial reduction of premiums below which it anticipated MICA writing since January 1, has sought to renegotiate the terms of the proposed contract to shorten the term of the agreement and to give them authority to cancel the agreement midterm and to provide for alternative means of being compensated. Because of this development, the contract has not been signed and has not been yet approved by the Division of Insurance.

Loan Funds

The Legislature provided for contributions to the surplus of MICA through surplus loans from a Health Care Providers loan fund, which in turn had the authority to require purchase of these loans by the State treasury.

The loans, which are fully subordinated, earn interest to the State at a rate four points over the federal discount rate, which at the time of the making of the first loan put the interest rate at 9.5%.

The capital base is required to support possible deficiencies in rating; operating expenses not captured in the premium during the period business is being added to the books, and to absorb statutory losses.

It was recognized that there was going to be substantially less than full participation during the formative months which meant that the initial capital needs would be less and there would be a reduced base over which to charge interest. Accordingly, it was agreed that MICA would begin operation with a base of only $1,000,000 with the understanding that the balance of $2,000,000 would be added as additional premiums came on the books.

Since there was no direct appropriation to the loan funds, the loan by the loan fund to MICA was sold to the Department of Revenue in a transaction simultaneous with the making of the loan.

Binding Provisions

The board recognized that the law provided that every physician was entitled to insurance from June 28, 1976 and for an additional premium and subject to certain restrictions, physicians could even procure insurance retroactively to January 1, 1975.

It was also recognized that adequate provision for evidence of insurance had to be accomplished at an early date in order that the Division of Occupational Licensing had documentation authorizing renewal of licenses by January 1, 1977.

Accordingly, the board established a procedure whereby applications would be sent to all physicians and physicians would be asked to make application for their insurance and would be issued binders from what ever date they indicated they wished coverage to commence, albeit, at the time the applications were sent out and binders issued, the method and amount of premium calculation was still being worked out.

Physicians were required to submit a deposit of $1,000.00 to bind their coverage with the understanding that when sufficient information had been received to calculate the premium and when the rates

had been approved, a billing would be given the physicians for the actual amount of premium they owe. Doctors who indicated on their application that they had no Alaskan exposure were permitted to submit simply their $100.00 minimum premium.

This enabled all physicians to be insured in minimum limits from whatever date they selected and to have physical evidence of that coverage by November 1, 1976.

Rates and Rating Plans

The most complex issue faced by the board was the matter of establishing an equitable rate plan.

Work on rates continued, performed mainly by the actuarial firm, but under the continual careful scrutiny of the Board of Governors. At every meeting proposals from Milliman and Robertson were reviewed, analyzed, and new instructions given for revisions, as the board labored over trying to make the rates adequate to cover the losses and equitably distributed among all of the physicians.

A couple of very basic principles must be kept in mind.

From the outset the board recognized, as a fundamental principle, that two separate issues were involved. First, collection of a sufficient amount of money overall to pay the anticipated losses and expenses and, second, the distribution of that cost among the physician and hospital population in the most equitable way and in compliance with statute.

The determination of what constituted a total aggregate premium began with a study of what actuaries referred to as "pure premium." That is to say, a determination of what losses would be expected to be paid as a result of the policies issued during the first year of the MICA operation.

The board rightly established as a principle that it would collect a sufficient amount of premium to cover all of the losses incurred irrespective of the date of payment and thus, attempted to study the total amount of losses that might be reported over the long period of time that the policies issued in the first year would be providing coverage.

Milliman and Robertson submitted an exhibit in which it made a recommendation as to a pure premium and the board considered carefully the actuaries recommendations, but the record of the activities of the MICA board clearly indicate that the work of the actuaries was revised and refined on numerous occasions. The actuaries revised their work papers eleven times between the orginal May 28 submission and the document finally submitted to the Director of the Division of Insurance as the MICA rates for approval.

Determining the pure premium, that is to say, the estimated amount of dollars which would be paid as a result of all losses incurred during the policy period, required study by the actuaries of statistics not wholey related to the State of Alaska.

As the actuaries pointed out, and of course as we knew from the work of the Commission going back to mid-1975, there was insufficient information in the State of Alaska from which actuarial projections could be properly made. That is to say, in actuarial terminology, the Alaska experience was not credible.

Accordingly, the actuaries looked to the experience in other states, the experience nationwide, and the experience in combinations of other states that could be said to more nearly represent the type of geo-political and geo-economic structure of the State of Alaska.

Actuaries are often charged with having been guilty of committing statistical narrowness. That is to say, it is assumed they deal only in the arithmetic calculations and mathematical computations from which perfect rates are calculated. That is not generally what actuaries do and certainly could not be the case in this particular assignment. A substantial amount of judgement had to go into what was done and, indeed, the actuaries and the board did engage in substantial judgement analysis to determine the propriety of the rates.

There is no particular magic in the selection of the data bases that were used for determining the MICA premiums, other than the fact that after having been selected, tests were made to determine the relevance to the State of Alaska of the data bases used and in the opinion of the actuaries and in the opinion of the Board of Governors, the data bases used seemed to correlate with expected Alaska norms.

The ultimate pure premium for the State of Alaska has resulted in an average pure premium per physician, which is perhaps a little higher than the rational average, but lower than is being used in numbers of other states in the Lower 48.

The average pure premium, which is a number that ought not to be ingrained too deeply in mind since it is only a beginning point in the overall rate process, is $4,550.00.

The next requirement was to determine the amount that must be added to the premium for expenses of operation.

The formula for calculating any rate for an insurance product is the sum of the amount necessary to pay losses and the amount necessary to pay expenses.

The expense element had to be sufficient to cover the maximum possible obligation to the management company distributed over the total population of physicians expected to be in the program.

There has been a lot stated, primarily by physicians, concerning the expense factor and some clarification is important.

There is provided an exhibit that shows the actual expenses which are projected by the MICA and how those work into the rates together with the total maximum amount which MICA would pay under the terms of the negotiated contract.

The exhibit shows that the maximum amount payable to the manager would have been between 16% and 18% of MICA's gross premiums assuming full participation.

Rate making is a two step operation; the determination of the total premiums required to be collected, which is the sum of the losses and the expenses of the corporation, and then the distribution of that amount over the insured community.

With an average premium per physician of $5,600.00 the problem now was to distribute that amount over the doctors to be insured.

Again, two premises should be kept in mind.

First, the law required that the rates not be discriminatory and authorized the rates to take into consideration classifications of physicians by degree of hazard.

This means that doctors were not all to pay identically the same rate since it would be discriminatory to charge an internist the same amount as was charged a gynecologist or an orthopedic surgeon.

It was appropriate, therefore, that gradations of risk be established and physicians be assigned into categories of risk.

The second is, that the statute mandates that all premiums be established as a function of medical revenue.

The requirement of medical revenue as the basis for premium was borne out of concern by some legislators that doctors retiring out of practice, physicians newly entering practice, and physicians whose practice was severely limited by the fact they practice in a bush community or receive little monetary compensation for the work they do and thus could not afford to pay the average high premiums of their brethran practicing with full time high revenue practices in Fairbanks or Anchorage The difficulty with the statute, however, is that by mandating medical revenue as the basis for determining premiums, physicians with very high revenues would be subsidizing physicians with very low revenues.

The second and more complex problem is that medical revenue has no legal definition. That is to say, "medical revenue" is not a word of art in the accounting or legal professions as is, for example, the words, "net income," "gross income," "gross receipts" or some other similarly familiar terminology.

The Board of Governors thus struggled, perhaps longest, on how to distribute premiums among physicians in accordance with medical revenue and to find an adequate definition of medical revenue.

The board appointed several committees to consider various aspects of this problem and called upon accountants to define the terms and explain the practical ramifications of the decisions they were making.

It became apparent that this issue, perhaps more than any other created, serious differentials between large clinics and private practitioners and thus caused a substantial amount of difference of view between the clinic physician and the private physician or the board.

The decision finally made by the board as to how the rate plan should be devised took into account the following considerations:

1. Rates would be determined by classification of physicians into hazard groups which were similar to but not identical with those used by the normal rating systems in other states.

2. The classifications would be adjusted to take into account both the local perception of the difference in hazards. That is to say, classifying physicians based on local view of comparative hazard, and since the physician's premiums would be a function of medical revenue, some thought was given to making adjustments in classifications to accommodate difference in overhead that different types of practices incur.

3. The relativities among hazard classes would be essentially those used on a national basis. The word "relativity" refers to the multiplier used to determine the difference between rates for a Class I physician and a higher class physician. That is, a relativity of 1.25 for a Class II physician, means that the Class II physician is paying 25 percent more than the Class I physician.

4. There would be an average pure premium established by classification. That is to say, that each class of physician must generate a certain average amount for all the physicians in the class.

   As a final step, the premiums would be determined as a function of gross professional charges within the classification based on information received by the actuary concerning the distribution of medical revenues in classificatons and among professionals within the classifications.

The rates were finally determined by the Board of Governors and approved by them and submitted to the Division of Insurance on September 8, 1976.

The Division of Insurance, mainly as a technical matter to set the stage for a public hearing, disapproved the rates and MICA asked for a hearing, which was held on October 6,7,8, and 9 in Juneau, Fairbanks, and Anchorage.

Seventeen persons attended the hearing on the first day of hearings in Fairbanks, thirteen of whom testified. On the first day of hearings in Anchorage, fifty-two persons attended the hearing, twenty-six of whom testified. Forty persons attended the hearings on the second day in Anchorage, twenty-two of whom testified and in Juneau, nine persons attended the hearings, six of whom testified.

In addition, forty-three exhibits were received in all, thus, indicating a substantial amount of interest in the hearings and a substantial amount of valuable information received by the Division of Insurance.

The Division of Insurance issued order number 76-2 on October, 21, 1976, which is attached as an exhibit to this report..

The order is thirteen pages long and includes a substantial amount of discussion of the rates, how they were calculated, and why the rates were ultimately disapproved in that order.

By new filings dated November 24 and November 30, MICA filed rate plans which were in compliance with the order and which were approved for use by MICA.

This rate plan is both comprehensive and substantially more responsive to the desires of the physicians, and a brief discussion is in order.

First, the average pure premium used in the final filing has been reduced somewhat because of reallocation of physicians among classifications and is now $4,450.00.

The proposed fixed expense per policy was reduced to $480.00 principally, by elimination from physician premium of a factor for risk management.

The new approved filing added a new rating element to recognize the difference between rural and urban practice. There is now a territory one which includes Anchorage and Fairbanks and territory two which is the remainder of the State. The difference in rates is approximately fifteen percent.

The rates now run from a low of $10.57 per $1,000. That is to say, a little over one percent of gross receipts in territory two for class 1A physicians to a high of $69.45 per $1,000 or just a little less than seven percent of gross receipts for a class 6 physician in territory one.

Further, the MICA Board adopted the rule that no physician would pay more than one hundred and fifty percent of the average rate for his class. That is to say, each physician has a maximum premium, irrespective of revenues, which ranges from a low of $1,659.00 for a class 1A physician in territory two to a high of $18,758.00 for a Class 6 physician in territory one. The doctor paying $18,758.00, the maximum premium in territory one for a Class 6 physician, would have to make $270,093 in gross receipts to pay the maximum premium.

In addition, the MICA Board established a minimum premium. That is to say, every physician applying for a policy must pay at least $100.00.

Bear in mind, that every physician holding an active license from the State of Alaska must procure the insurance. This includes physicians who are devoting a hundred percent of their time to military service or who are retired but choose to maintain an active license, or who reside outside of the State of Alaska.

These doctors will receive a policy and will receive full medical malpractice insurance coverage and need pay only the $100.00 minimum. Obviously, if they generate Alaska gross receipts, then their premiums will increase proportionately to the amount of gross receipts they generate.

Physicians, even those that generate no exposure whatsoever, would still pay the minimum $100.00.

Utilization

To date, one hundred and sixty-seven physicians have applied for and been issued insurance. Of those, one hundred and thirteen have submitted a deposit of $1,000.00 indicating they are doctors practicing with more than nominal exposure in the State. The balance have submitted $100.00 indicates that they are purchasing a policy in compliance with the law to validate their active license.

In addition, eighteen hospitals have applied or are in the process of applying for insurance, however, the hospital situation is somewhat more complex because there are provisions in the law which permit hospitals to obtain their own insurance upon the compliance with certain conditions and, the issue of whether they will be permitted to utilize their own insurance has yet to be resolved.

Reinsurance

It should be recalled that the law provides that MICA may, up until June 28, 1978, procure any layer of reinsurance which the board believes in the best interest of MICA.

In addition, MICA is authorized to provide insurance up to $1,000,000.00 limits to physicians and $5,000,000.00 for hospitals. The Division of Insurance has indicated to MICA that MICA should not issue limits beyond the mandatory $200,000.00 - $600.000.00 until reinsurance of the excess layers has been obtained. Thus, the matter of reinsurance and the matter of excess limits are closely related.

The MICA Board and the Division of Insurance have been working diligently to procure reinsurance for the business of MICA.

There have been two essential kinds of reinsurance for which the search has been going on.

First, the Division of Insurance and the board is concerned about the exposure to MICA in the event of multiple defendants.

Obviously, MICA would be obligated to pay no more than $200,000.00 per incident per physician. Thus, if one physician is sued, the maximum exposure for MICA is $200,000.00. On the other hand, the more usual occurrence is a law suit involving multiple defendants, probably the hospital, the surgeon, the general practitioner, the anesthesiologist and, perhaps covered nurses. It is the opinion of all involved that both the law and the terms of the policy and the intent of the Legislature, is that there would be protection in the amount of $200,000.00 for each separate defendant. Thus, out of any one incident, MICA could be obligated to pay as much as $1,000,000.00. This is the kind of catastrophic loss which MICA would be unable to sustain on a continuing basis, and reinsurance against catastrophic loss where two or more defendants are involved, is being sought

Second, MICA is attempting to locate reinsurance for the layer of $800,000.00 above the first $200,000.00 of exposure for each insured That is to say, reinsurance to enable MICA to provide the higher limits of insurance to each physician, which the physicians would like to have.

The search is still going on, and to date no reinsurance has been consumated. However there have been a number of very positive indications that reinsurance of MICA is available.

First, a reinsurance broker in Seattle has been working with American reinsurance sources and has been successful in obtaining a commitment from an American company to provide a layer of excess reinsurance involving multiple defendants on a retrospectively rated basis. This proposal is currently being evaluated by the MICA actuaries and, early indications from the actuaries suggest that the reinsurance may have some value to MICA although, it is at very high cost.

Second, I have engaged in negotiations with the CNA insurance group in an effort to have the program that they have been successfully providing to clinics, continued in the State of Alaska utilizing the MICA as a front carrier in order to comply with the law. We have been successful and CNA has agreed to provide such a program, however, further negotiations with CNA have been suspended because of some communications from clinics to CNA asking CNA not to provide the program to MICA.

Third, a broker in Anchorage is working closely with a London Lloyds broker to procure reinsurance in the foreign markets. Just recently, I have received indications from the Alaskan broker that an excess reinsurance program can be made available to MICA although, the aggregate limits and the cost are still not to the levels to be of the best benefit to MICA. In addition, the Alaska broker is including with the excess reinsurance for MICA a program of excess insurance for each individual physician which would enable each physician to procure on a voluntary basis, his own layer of excess above the limits provided by MICA and also, provide MICA with protection against its own catastrophic losses.

I have been in contact with yet another American reinsurance market and discussions have led to the anticipation of a proposal for reinsurance of MICA and/or reinsurance of a voluntary excess market to provide both catastrophic excess reinsurance for MICA and individual excess limits of coverage for each individual physician.

While this brief resume of reinsurance may seem somewhat technical, in summary, it can be stated that there are four separate programs that are currently being negotiated any one of which, or combination of which, could lead to a successful reinsurance program which would protect MICA against catastrophic loss and which would enable each physician to have protection up to at least $1,000,000.00 per incident.

Physician Discontent

Any report on the affairs of MICA would be incomplete if there was not mention made of the substantial amount of physician concern over the way MICA was implemented and the current view of many local physicians concerning their new feeling about the new law.

During the months in which the board was formulating the plans for the operation of MICA and preparing the policies and rating plans, there was perhaps inadequate communication with the broad physician community. When the rates and rating plans were finally exposed and then submitted to the Director of the Division of Insurance for approval and ultimately, a hearing, substantial confusion and misunderstanding

reigned among physicians and it became very apparent at the hearings that physicians had an entirely new perception of what the impact of the law was and concern over how it was to be implemented.

This discontent grew into substantial resentment against the MICA, against many of the people on the board and probably, even against the Director of the Division of Insurance.

The focal points for discontent centered on the gross receipts or professional charges method of calculating premium, on some of the decisions by the MICA Board concerning methods of handling claims, and on a variety of other issues, some of which are substantial and some of which are technical. As the medical community dwelled on the issues of how the MICA implementation was going to impact on their practice, many physicians began to be very concerned that they had no escape from the effects of MICA because of the mandatory and exclusive provisions in the law. By the time of the rate hearings, most of the attention became channeled to that one aspect of the law and a substanntial amount of testimony was taken concerning the undesirability of MICA and the undesirability of the mandatory and exclusive provisions of the law.

Of course, as a result of the order of the Division of Insurance concerning rates, many of the things which the physician expressed early concern about, such as the method of calculating premium, policy forms, and so forth, have been remedied, but the doctors have not ceased to be concerned about the fact that they are mandated into a program and thus, have no reasonable means of disassociating themselves from the program should they not desire to continue it.

This discontent has resulted in several different phenomena.

First, a number of physicians have filed a law suit against the State raising as the principal issue, the constitutionality of the mandatory and exclusive provisions of the law. There are two such suits now pending. The first and perhaps, the most formidable in terms of the number of plaintiffs involved, is the Rogers vs. State of Alaska Case, which involves principally the clinics who will be forced by virtue of the law to give up their very favorable medical malpractice insurance program with CNA.

There is a third suit denominated Romig vs. State of Alaska which also raises the issue of the constitutionality of MICA, but based on issues other than mandatory and exclusive. The Romig case raises as issues, questions concerning the propriety of the way in which the law was adopted and the way in which MICA is funded.

There is also, a fourth law suit which was filed by the Alaska State Hospital Association simply for the purpose of protecting the hospitals against the eventuality that they would have to remain open with only unlicensed physicians practicing in the hospitals. The Hospital case has raised no substantive issues.

Three of those cases, the Rogers case, the Hospital case, and the Mills case have been set for trial on March 29 of this year. Also, there is a preliminary injunction issued out of those cases ordering the State of Alaska to proceed to issue licenses to all physicians in the State who qualify for a license in all respects except the failure

to obtain insurance. The preliminary injunction does provide some protection for MICA, in that, if the court ultimately determines that the law is constitutional, all physicians will be required to purchase the insurance retroactive to the date they normally would have been required to purchase the insurance had the constitutionality of the law not been challenged.

The order also provides a procedure for those physicians who are not parties to the law suit to take advantage of the preliminary injunctive relief by accepting limited jurisdiction of the court and agreeing to the terms of the preliminary injunction. Those physicians who enter such an agreement will receive their license to practice medicine without the necessity of purchasing MICA insurance until such time as the court determines the constitutionality of the mandatory and exclusive clause.

There is yet another phenomena which is somewhat less visable than the law suits that have been filed and yet, it is one of which I believe we all must take cognizance.

There are a substantial number of physicians who have not filed a law suit, who wish the MICA to continue in existence, but who are adamantly opposed to being mandated into the program. These physicians have indicated that no matter what the courts or the Legislature or the Administration does or fails to do, they will not buy insurance from the mandatory program and will practice without licenses or in violation of the law.

I believe it is unfair for me to comment on whether that is an appropriate reaction of the physicians under the circumstances or even to comment whether such is a real possibility. Nonetheless, there have been physicians who have indicated such possibilities to me and while it is for the Legislature to determine the truth of those statements, it nonetheless indicates the degree of objection in the minds of some physicians to certain portions of the law.

The Administration, and particularly the Division of Insurance and the Department of Commerce and Economic Development, is carrying out the mandate of the Legislature. The MICA is functioning and will continue to provide insurance to those doctors who wish to pay the premium and procure the coverage. The Division of Occupational Licensing will issue licenses in accordance with the order of the court issued in the Rogers case.

More importantly, however, the Administration and particularly, the Department of Commerce and Economic Development and the Division of Insurance are continuing to explore ways to satisfy the legitimate concerns of those physicians that feel that further legislative action is needed. It should be of interest to you that the Director of the Division of Insurance will meet next week with representative physicians for the purpose of exploring common grounds for further legislative action.

10-1-76

Exhibit IX

MEDICAL INDEMNITY CORPORATION OF ALASKA

Provision For Expenses[1] - Physicians And Surgeons And

Hospital Professional Liability

	(1) Physicians and Surgeons	(2) Hospital Professional Liability	(3) Total (1)+ (2)
A. FIXED EXPENSE[2]			
(1) Underwriting	$114,000	$ 6,000	$ 120,000
(2) Safety Engineering	60,000	20,000	80,000
(3) Other Expense[3]	85,000	15,000	100,000
(4) Subtotal (1)+(2)+(3)	259,000	41,000	300,000
(5) Adjusted Subtotal	244,000[4]	41,000	285,000
(6) Estimated Exposure	375[5]	600[6]	--
(7) Fixed Expense Per Exposure (5)÷(6)	650	68	--
B. VARIABLE EXPENSE[2]			
(1) Unallocated Loss Adjustment Expense	3.0%	3.0%	--
(2) Taxes	1.5%	1.5%	--
(3) Profit and Contingencies	2.0%	2.0%	--
(4) Total (1)+(2)+(3)	6.5%	6.5%	--
C. AVERAGE PERMISSIBLE LOSS AND ALLOCATED LOSS ADJUSTMENT EXPENSE RATIO			
(1)	.816	.869	

NOTES:

1. Allocated Loss Adjustment Expenses are included with losses and are therefore excluded from these expenses.
2. Fixed Expense is a fixed charge per exposure; variable expense varies with written premium.
3. Other expense includes insurance, governors' fees and travel expenses, legal, actuarial and auditing fees and examination costs. .
4. We estimate that approximately 150 Physicians will pay minimum premiums of of $100. This $15,000 will be used to offset total fixed expenses as follows: $259,000 - $15,000 = $244,000.
5. Excludes estimated number of physicians who will pay minimum premiums.
6. This number represents the number of equivalent occupied hospital beds (class 1) based on estimates of total beds and outpatient visits for all classes.

STATE OF ALASKA

DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT

DIVISION OF INSURANCE

POUCH D

JUNEAU, ALASKA 99811

Order 76-2

Re: Medical Malpractice rates and forms filed September 2, 1976 and amended October 1, 1976, by the Medical Indemnity Corporation of Alaska.

To: All Licensed Physicians and Hospitals in Alaska
All Authorized Property and Casualty Insurers in Alaska
All Licensed Property and Casualty Agents and Brokers in Alaska
All Authorized Disability Insurers in Alaska
Medical Indemnity Corporation of Alaska

The Director of Insurance does hereby find, as follows:

Background

1. The Medical Indemnity Corporation of Alaska (MICA) did file on September 2, 1976, a proposed rate, rating plan and physician policy form for approval by the Division. On 9-14-76 the filing was disapproved because it was incomplete.

   On 9-20-76 MICA asked for a hearing pursuant to AS 21.39.170, and hearings were noticed for October 6, 7, 8, 9 in Fairbanks, Anchorage and Juneau.

2. Notices of Hearings were duly posted to MICA, all admitted property, casualty and disability carriers and health care contractors, licensed agents, brokers and all licensed physicians and hospitals in Alaska on September 21, 1976. Certificates of mailing, as part of the record of the hearing, confirm that all notices were duly mailed over ten days prior to the date set for the hearing.

   MICA, through their casualty actuaries, Milliman and Robertson, filed a supplemental document dated October 1, 1976, which is a comprehensive rate plan including the statistical support for the rate levels. It is this document which was the subject of the hearing.

History

3. The MICA came into existence June 28, 1976, by virtue of Article 2, of Chapter 88 of Title 21, Alaska Statutes, which was enacted as part of a comprehensive medical malpractice insurance law, 1976 Alaska Statutes, Chapter 102.

4. It must be observed that the consideration of rates and forms for MICA is one of the final steps in the implementation of a comprehensive solution to the medical malpractice dilemma which was first brought to public attention in early 1975 by a group of active physicians seriously concerned about the apparent widespread unavailability of medical malpractice liability insurance. The solution finally adopted by the legislature is not dissimilar from the solution recommended to the Governor of the State, Jay S. Hammond, in October of 1975, by the Governor's Medical Malpractice Insurance Commission.

5. Three important elements characterize both the Commission's recommendation and the legislature's final version:

   a. It is an integrated plan involving interelationship of changes in both the substantive and adjective aspects of the judicial system for determining loss, a system for better control of the medical care delivery system, and a uniquely Alaskan plan for indemnifying liability.

   b. An insuring provision is included even though the evidence is clear that Alaska has not had and does not now have an adverse loss experience. The insuring provisions are made necessary because factors unrelated to Alaska's unique facts have made insurance unavailable to many physicians at reasonable rates and the changes to the judicial and medical administration system alone would not have an immediate impact on the voluntary insurance markets.

   c. The insurance plan would be totally loss responsive within the insured population. That is, the physicians and hospitals would pay the full cost of all claims and expenses and all savings in loss or expense would inure to the benefit of the insured health care providers.

6. The rate filing, being the initial filing for the company includes a comprehensive actuarial analysis of the total state pure premium needed to properly fund the expected losses of the MICA, as well as a detailed rating plan. The filing will be considered for convenience in three parts.

   a. Propriety of overall statewide pure premium;

   b. Propriety of expense factors included in the rate;

   c. Propriety of the rate and rate plans proposed.

Overall Statewide Pure Premium

7. One of the most difficult tasks facing the management of a new insurance enterprise, or even an existing insurance enterprise entering a new line or new jurisdiction, is the projecting of estimated total losses. It requires considerable judgment to anticipate which and to what degree factors will have an impact on the frequency and severity of loss.

After several years of writing the business subject of the rate calculation, statistics become available which help to quantify the judgments but history has amply demonstrated that even with an amplitude of numbers, empiric analysis of the expected variables which may differ in their future effect from their measured past effect is requisite. Thus it must first be noted that the filing is based to a large degree on subjective analysis. Testimony taken at the hearing made it clear that analysis of available national and regional statistics were utilized, but mainly to validate the more subjective determination.

8. The new law specifies that the rates may not be excessive (AS 21.88.080 (4)) or inadequate (AS 21.88.080(5)). Both terms are defined. The definition makes it clear that all losses, including those paid, those which have been reported but unpaid and those which occur but are not reported, must all be accounted for in the rate. The definition of "excessive" includes language not included in the definition of "inadequate." A rate becomes excessive "after a period of time and with respect to an amount of gross premium which is actuarily credible...;" that is to say, as the corporation's long term loss development indicates that premiums exceed losses, reserves and expenses, the premium may be adjusted downward. It would be inappropriate at this stage to anticipate excessiveness in the rate provided all other data indicates that the rate level is generally within an acceptable range.

9. It must be further noted that even if modest redundancy develops in the rate there is no loss to the physician community. One of the unique features of the Alaska solution which distinquishes the MICA from other insurance programs is that it is exclusively Alaskan. If redundancy develops over time, it is not lost to adverse loss development in other lines or other states which might be insured under that program. Alaska Statutues 21.88.030 (8) provides that the excessive portions of the rate be returned to the physician in the form of downward adjustments in subsequent years.

10. In considering the propriety of rate level the law also provides (AS 21.88.080 (9)) that "changes in the law, national, regional or local trends in medical negligence awards and other relevant factors may be considered."

There is a total lack of credible data on Alaska medical malpractice losses. This is both good and bad; good because one of the reasons for the absense of loss data is the fact that Alaska physicians have enjoyed a low incidence of loss; bad, because the actuaries are left with little upon which to build rates for future periods without heavy reliance on indications from out of state.

11. In developing a proposed rate level MICA began with unrefined pure loss statistics taken from the Insurance Service Office (ISO), a rating and statistical agency for the insurance carriers writing the predominate share of medical malpractice insurance nationwide, and refined the data using techniques developed by their consulting actuaries.

From that information pure premium per physician was developed for five western states and combined with countrywide data to develop a weighted average pure premium which MICA contends would be suitable as a beginning estimate of future losses for Alaska.

The rationale for selecting the states of Arizona, California, Nevada, Oregon and Washington as the states most relevant to Alaska could be argued forever without adequate resolution. The test for the Division of Insurance is whether the utilization of those states is unreasonable. All four states (excluding California) might be said to parallel Alaska geo-politically in that they are each essentially rural states with a few highly concentrated urban centers.

The inclusion of California was dictated by the observed trend in Alaska to a rapid influx of new people, mainly from California, a trend toward industrialization and an observed change in the attitude of juries and jurists to follow the liberal trend in awards and judicial interpretations very obviously impacting liability costs in California.

The Division tested the proposed pure premium to determine the degree to which the rate level is impacted by the obvious disparity of the California indicators from the norm of other data by recalculating the selected Alaska class 1 pure premium by excluding from the calculation the highest (California) and the lowest (Washington) data inputs. The resulting calculation is a difference of less than 8% from the proposed pure premium. The use of the data as a starting point is thus not unreasonable.

12. The per physician average pure premium was developed by using nationwide class relativity estimates and increased limit factors derived from the consulting actuaries' analysis of national data. The class relativities, however, were weighted based on the distribution of Alaskan physicians among these classes.

The resulting average per physician pure premium is then an amalgam of statistical data taken from states perceived by MICA and their consulting actuaries to be relevant to Alaska and judgemental analysis of factors considered significant to expected future losses.

The estimated average pure premium per physician will yield $1,668,000 in funds available to pay losses.

If an assumption is made that the average value of loss is $25,000, and the assumption is supported by statistics available to the Division showing that the national average cost of claims including allocated loss expense is $20,000 with respect to closed claims; then there is sufficient funds to pay 66 average claims, or one for every seven physicians licensed in the State. In view of the favorable claim history in Alaska this would appear to be ample allowance for claims and thus not an inadequate pure premium.

The concern of the Division lies mainly with possible redundancy in the pure premium, however, the division's policy with respect to this insurer is to urge conservatism. If there is ultimately a favorable loss development, the benefit will inure to the benefit of the physicians in subsequent years.

Appropriateness of the Expense Factors

13. Once the pure premium is determined, an element must be added to the rate to cover administrative expenses.

14. It should be noted that this order deals with the approval of the rate and the expense element included in the rate. This order should not be construed as approving the expenses themselves. That is, this order deals with the propriety of the charge made to insureds to cover the expenses and does not deal with the propriety of the charges made to MICA by the servicing entity.

    The contract between MICA and Alaska Pacific Assurance Company (ALPAC), the designated servicing carrier, must still be submitted to the Division for approval and will be the subject of a separate order. Further, the ongoing operations of MICA are subject to constant surveillance by the Division and judicious expenditure of funds is always at issue.

15. MICA will contract for all of its services with ALPAC, and ALPAC will charge a management fee, the amount of which being arrived at by negotiation.

    The chairman of the Board of Governors of MICA, William Brock, described the proposed servicing contract management fees as being stated separately for each major category of service. Exhibit IX of hearing Exhibit 7A indicates the level of expenses per category.

    The testimony indicated that no flat amount is being paid to ALPAC but rather ALPAC will be paid direct reimbursement of cost for each service, subject to fixed dollar maximums. The reimbursement amounts are subject to audit by the MICA's auditors. During the term of the agreement advances will be made to ALPAC in amounts determined as a percentage of total premium.

    This arrangement is the most advantageous for MICA since MICA can control the level of expenditures and further level its cash flow even though the typical insurance operation would have heavy expenses during the formative months.

16. The question then is has the rate been structured to include sufficient funds to pay ultimate expense or has the rate been structured to include an excessive amount for expense. It is apparent that the rate was structured to include sufficient expense dollars to cover what is anticipated as maximum allowable charges and thus cannot be considered inadequate.

The important question is whether the expense amounts are excessive. The allowance for underwriting of up to 6% of premium must be evaluated in the context of the substantial start-up expenses which includes printing of forms, development of computer programs for recording of premiums and loss information and presentation of statistics in accordance with division requirements and maintenance of all records and accounting information required by the Division.

The Division has available statistics from private insurers which indicate that these expenses normally run higher as a function of premium than the six percent allowed for in this proposed rate.

Thus, though the dollar amount seems high, it does not appear an excessive element in the rate. It does appear, however, that after the contract is approved and after a clearer view of actual expenses can be obtained, a further review of this element would be in order.

17. The loss control element in expense is regarded as appropriate principally because the legislature clearly comtemplated risk management as an important segment in the medical malpractice solution. One of the carriers currently providing an insurance program for physicians develops favorable results by emphasizing the risk management features of its program. The total dollars allowed, thirty three percent of which have been attributed to the hospital program, will enable the funding of initial program development and participation in the promulgation of risk management regulations as provided by law. This element should become one of the more important expenditures of MICA and while the amount allowed in the first year may exceed what is actually going to be expended during the first year, the contemplation of this level of expenditure on an ongoing basis is consistent with the development of a total malpractice insurance program that is workable and effective.

18. The most critical concern of the division centers on the profit and contigency element for which an allowance of 2% has been made. The Division believes that the method for allowing for profit to ALPAC should be based on some method other than as a function of the MICA premium. This matter will be further reviewed when the Division receives the management contract for approval. However, it is not inappropriate to include the 2% factor for purposes of arriving at a rate.

It should be noted that all expenses (except investment expense) total less than 17% of premium. This is generally regarded as an extremely favorable expense ratio for a malpractice insurance book of business and while the matter of expense elements must be continually reviewed carefully, the current level of maximum expense cannot be considered excessive.

Rate and Rate Plan Proposed

19. The rate plan, it must be observed, is extremely unique. No other medical malpractice rate plan either voluntarily or under mandate of law bases its premium on medical revenue. For that reason, the MICA is plowing new ground. The problem is rendered even more complex because "medical revenue," the term used by statute, is undefined and it is eminently clear from the testimony that no single generally acceptable meaning of these words exists.

20. Much testimony was taken at the hearing concerning the intent of the legislature on this point, and while it may never be settled as to the true cumulative intent of the legislators, all of the following possible purposes played some part in causing medical revenues to become the basis of calculating physician premium.

    a. There was perceived a correlation between revenue and risk. While revenue was never clearly defined, it was stated that the larger or more sophisticated the physician's practice, and thus the larger the risk, the more his revenues, however measured, were likely to be.

    b. Physicians in rural Alaska performed a valuable service but received compensation far less than what is commensurate to their practice and less than their urban counterparts. Recognition of this fact and avoidance of burdensome malpractice premiums for these practictioners was a further reason for scaling premiums to other than the traditional class system.

    As a matter of fact, the legislature may have created more problems than it solved by requiring all physicians' premium to be a function of medical revenue since that feature of the law effectively ties the hands of the MICA. Nevertheless, the MICA has submitted a filing which complies with that feature of the law.

21. In determining a definition for "medical revenue" the MICA elected to use "professional charges." This means that gross receipts or net income, or other possible alternative definitions of medical revenue were either considered by MICA and rejected or were not considered even though it became clear at the hearings, that of all the possible methods of determining revenues, "professional charges" is the most disfavored by the physicians.

    The physicians argued that the "professional charges" basis of calculating premium would seriously disrupt the medical care delivery system primarily because it would encourage physicians to discontinue seeing patients whose costs are paid by Medicare and Medicaid. Medicare and Medicaid reimburse physicians based on a profile of medical billings which is developed for each physician over a several year period. If the physician increases his fees over that period, his fees will, in a current year, be higher than the profile of fees and thus higher than what these governmental programs will allow to be paid to the physician. The predominant differential today between allowable reimbursement and current level of medical billings amounts to between 20% and 40%. The premiums for malpractice will average 3%-5% of total estimated billings. Medicare and Medicaid patients account for approximately 6%-15% of a physicians practice.

taking these factors at the extremes, the impact of using professional charges as opposed to collected receipts as the basis for premiums would amount to less than 1/2 of 1% of physician billings and could have almost no impact on the physician motivation to see those patients. Certainly if physicians developed their patient constituency purely upon economic motivations, the Medicare and Medicaid reinbursement systems themselves should have a far more compelling effect.

22. The physicians also expressed concern over the need to disclose confidential information in order to permit calculation of premiums based on professional charges. It is true that physicians currently report gross receipts to the state and cash basis income calculations to both the state and the federal government for gross receipts and income tax purposes. Professional billings, which includes uncollected charges, would be a new accounting requirement for physicians.

The requirement, however, ought to impose no significant burden on the physician. Professional charges are recorded in the physician's records and thus can be verified and reported. The matter of confidentiality is, however, more troublesome. MICA can take every precaution to assure the confidential treatment of physician supplied data and can minimize the audit of physician billings records to its bare essentials but there is no effective guarantee against the inadvertant or unauthorized release of these matters and thus if an alternative method of calculating premium is available that is equally fair, it should be considered.

23. These arguments raised by the physicians against professional charges as a basis of setting premium, as weak as they may be, obscure the basic issue. When the total malpractice plan was conceived by the Commission, the principle advantage of a plan which includes all physicians in the state and only physicians in the state is that the physicians could determine the method of payment of that premium and the distribution of the cost of claims among the physician community. Testimony of members of the state administration before the Commission and the legislature was clear. As long as total dollars collected by the insuring mechanism was sufficient to discharge all of its obligations, the physicians could determine how that cost would be distributed among themselves, except, however, no method advocated by the physicians could be allowed if it violated the rate law.

24. The physicians at all hearings made it clear. Professional charges is not favored. Gross receipts is a much preferred basis by the physicians.. There are certain advantages to gross receipts both from the physicians' perspective and for MICA.

   a. The physicians and their accountants already prepare gross receipts data for the state gross receipts tax return.

   b. The information can be easily verified by a simpler audit or by certification by the physicians' C.P.A.

   c. It eliminates the need for MICA to review individual patient records.

The gross receipts basis does part, to a degree, from a strict measure of risk, however, the differentials are of such a small magnitude as to not be regarded as unfairly discriminatory. Gross receipts is an acceptable definition of medical revenues. It is not an unfairly discriminatory method and is clearly the physicians' preference.

25. If the basis for calculating premium changes to gross receipts then the justification for a separate rate for ancillary charges is called to question. One of the problems clearly presented at the hearings was the difficulty in determining what are professional charges, charges for professional advise and interpretation, and ancillary charges, for goods or supplies. A radiologist for example takes an x-ray and interprets the indication on the film. For this service he makes a single charge. The physician ordering a lab test or x-ray may add an increment to his cost for the lab test or x-ray and bill the patient as an ancillary charge. Really much of what the radiologist does and all of what the treating physician does is render professional advise and thus the billing should be categorized as professional charges. This problem is avoided by eliminating the distinction between ancillary and professional charges.

On the other hand, there is a problem of equating the x-ray performed by an internist and thus included in the malpractice insurance premium at a low class and the x-ray performed by a surgeon and thus included at the higher class.

The answer to this apparent inequity is that the premium is not being calculated on a per procedure basis but on the basis of the average level of expense presented by the physicians. This point is important, not only as it relates to this issue but is important in recognizing the basic underpinning of the whole rate calculation.

A certain sum of money must be collected for each physician in a class. No matter which basis is used for calculating premium the same average dollars for all physicians in that class must be collected. Thus, if ancillary services are treated differently from professional services, then the rates must be adjusted to result in the same average per physician premium in the class. If a class 1 physician performs an incidental procedure normally performed by a class 5 physician, a separate charge for that procedure in the higher class would result in a higher average premium per physician in the lower class; probably more than the statistics dictates as necessary.

26. It is obvious that the physicians want a rate plan that is simple to administer, easy to verify, and yet fairly represents the risk.

Each refinement in the plan tends to make it more reflective of risk and less simple.

Since ancillary charges as a separate element in the rating adds to the complexity of calculating rates, particularly if gross receipts is the basis, the distinction between receipts for professional services and ancillary charges should be eliminated.

The clinics are presented with the requirement of allocating ancillary charges among the physicians in the clinics. This can be accomplished with a simple allocation formula or average premium rate for ancillary services.

27. In certain communities physicians purchase services both professional and ancillary from other health care providers who are covered by MICA. For example, a physician may require a patient to receive lab tests or x-rays at a laboratory or hospital. The pathologist, radiologist or hospital bills the treating physician. The treating physician adds a service increment to the charge and bills the patient. The physician would have his premium calculated on the receipts from the patient, the pathologist or radiologist would have his premium calculated on receipts from the physician, resulting in duplicate premium for the same service. This can be avoided if each physician is allowed to take as a deduction from his receipts, the amount paid to another physician insured with the MICA.

28. The classification of physicians used in the rate plan contains certain ambiguities, particularly when coupled with the definition of major surgery. The actuaries testified that the classifications were essentially those used by the I.S.O. and are justified by national statistics showing degree of risk by specialty. That being true, it must be assumed that the statistics include exposure to which the physicians are subject when performing procedures normally within the scope of their specialty. Thus, if a radiologist might normally be expected to inject barium, or an internist insert gastroscopic implements, these should not result in higher classifications even though the procedures might technically be classed as minor surgery. Further, many physicians perform procedures in their office which might be classed as minor surgery.

On the other hand, some of the physicians testifying rightly pointed out that the class 1 physician performing occasional major surgery or even occasional minor surgery may be a higher risk than a specialist performing the same procedure and certainly is a higher risk than the class 1 physician who does not perform incidental surgery.

It would make greater sense to reclassify the MICA Class 1, 2, and 3 physicians by including the family practitioner in the list now a part of class 1. The distinction then between class 1, 2, and 3 would be based on whether they engage in no surgery, minor surgery or major surgery. "No surgery" should be defined to include all procedures normally a part of the specialty for the physician and also procedures which good medical practice dictates is appropriately performed in the physician's office.

Merit Rating Plan

29. Merit rating is an important part of a good rate plan. It serves to partially recognize differences in risk and provides some economic incentive to do those things which are perceived to improve risk characteristics.

30. Part of this merit rating plan concerns claims filed and claims paid. It has been well stated that the fact of a claim being filed or paid is of itself not an indication of whether the physician is a good or bad physician. The Division believes that to be true. The Division notes however that the fact of filing only one claim creates no surcharge. On the other hand the issue is not whether the insured is a good doctor but rather whether he subjects the program to a risk of being sued more than other physicians. A physician who in a four year period has two separate incidents blossom into filed law suits indicates that he is a greater risk to the insurance program than physicians without filed claims. The physicians are protected against having their rate increased because of purely nuisance suits in four ways:

    a. The first filed claim results in no surcharge.

    b. Settlements under $10,000 result in no surcharge.

    c. Suits which are found patently frivilous result in no surcharge, and

    d. Suits filed over four years prior to the policy period result in no surcharge.

31. The merit rating plan also contemplates a charge for using an arbitration agreement not approved by the MICA. Arbitration agreements are now given statutory recognition and thus are favored as part of the total malpractice solution. The degree to which arbitration will reduce ultimate cost is now not known and thus no debit or credit can or should be given for physicians using arbitration agreements. MICA would be bound, however, by an arbitration agreement as to the way in which the determination of liability is made and it is unfair to make obligated to discharge a claim incurred by a physician who executes an unsound arbitration agreement. Thus it is vitally important to MICA that it review the arbitration agreements to assure that they provide adequate protection for MICA. The surcharge for using arbitration agreements which have not been reviewed by MICA is thus justified.

32. MICA further proposes a 10% credit for physicians in group practice accredited by the American Group Practice Association. There is ample justification for this credit. The AGPA accreditation program includes rigid peer review and medical practice control systems that have demonstrated favorable impact on loss expenses. The MICA proposes that this credit apply after January 1, 1978. The Division fails to comprehend why, if there is demonstrable risk advantage to the criteria that qualify a group for AGPA, that credit should not be given effective immediately.

The AGPA has sponsored an insurance program through CNA which is currently written, profitably, at favorable rates; rates substantially less than charged of physicians outside the AGPA program and less than proposed MICA rates. Review of that program indicates that its success is based on several key loss control criteria which are imposed upon the clinics as a condition of acceptance into the program. It seems appropriate that any group or individual that meets the same criteria ought to have the credit as soon as the compliance with the criteria is established.

Policy Form

33. The physician policy form is essentially a standard insurance form but it contains provisions unique to the MICA. The Division regards the form as appropriate except to the extent it requires the physician to submit to audit of financial records. This becomes unnecessary in light of the change in premium base.

Excess Coverage

34. The Division is deeply concerned about the probable unavailability of insurance coverage above the current $200,000/$600,000 limits. Insufficient evidence was presented at the hearings to permit a determination that MICA could provide excess at reasonable cost. The Division believes that this matter ought to be reviewed further and that MICA should develop proposed rates for an excess program.

The Director Hereby Orders:

A. The rates and rate plan filed with the division and dated October 1, 1976, are hereby disapproved.

1. MICA shall forthwith refile a rate plan and rates that are consistent with the finding and orders herein.

2. The rate plan shall define "medical revenue" as "gross receipts" as the term is used by the State of Alaska Department of Revenue for purposes of the State gross receipts tax.

3. Each physician shall be allowed a deduction for amounts paid to other physicians for professional or ancillary services, provided the other physicians are insured by MICA and paying premium based on gross receipts including the receipts from the physician claiming the deduction.

4. The distinction between ancillary services and professional services shall be eliminated.

5. MICA shall submit a reclassification of physicians currently in their classes 1, 2, and 3 that accomodates to the concern of the Division expressed in the findings.

6. The 10% credit for AGPA accreditation and for compliance with the risk management and loss control criteria shall be given effective immediately.

7. The filing shall include such adjustments as are made necessary by the required changes in order to maintain the overall statewide rate level.

8. In all other respects the filing is deemed appropriate.

B. The physician policy form is hereby disapproved.

1. The policy form shall be refiled forthwith amending the provisions for audit of physician's financial records to comply with the finding and orders herein.

2. The policy form is otherwise deemed appropriate.

C. No finding is made at this time with respect to the necessity of MICA providing excess coverage. MICA should prepare proposed rates for excess insurance and submit to the Division by December 10, 1976.

D. The MICA shall prepare the necessary hospital forms including collateral coverages, such as premises liability and shall be prepared upon approval of such, to offer this coverage to licensed hospitals and nursing homes.

Done this 21st day of October, 1976.

Richard L. Block
Director of Insurance

Medical Indemnity Corporation of Alaska
1007 West Third Avenue - Suite 200
Anchorage, Alaska 99501
Telephone (907) 272-8024

November 30, 1976

Please reply to:

APPROVED
NOV 30 1976
ALASKA DIVISION OF INSURANCE

Mr. Richard L. Block
Director, Division of Insurance
Department of Commerce & Economic
Development
Pouch D
Juneau, Alaska 99811

Dear Director Block:

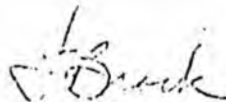
You have recently received and approved the amended filing memorandum of MICA dated November 23, 1976, which contained various changes from the memorandum of October 1, 1976. A number of these changes, as you know, resulted from the directions contained in your order 76-2 disapproving that original filing. Two important points not disapproved by your order have not been specifically restated in the amended filing memorandum, specifically:

1. A 10 percent surcharge on premiums for any physician utilizing an arbitration agreement other than one approved by the board of governors.

2. The options for payment of premiums in installments, including the requirement for payment of interest on deferred balances, as outlined on page 5 of the October 1, 1976 memorandum.

While these points have not been reiterated in the amended memorandum, they remain an integral part of the corporation's rate structure and rating plan, and we should appreciate your confirmation that they are included in your approval of the plan as filed.

Sincerely,



William G. Brock
Chairman

Medical Indemnity Corporation of Alaska
1007 West Third Avenue · Suite 200
Anchorage, Alaska 99501
Telephone (907) 272-8024

November 24, 1976

Please reply to:

APPROVED

NOV 2 6 1976

ALASKA DIVISION OF INSURANCE

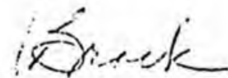
Mr. Richard L. Block
Director
Division of Insurance
Pouch D
Juneau, Alaska 99811

Dear Director Block:

Enclosed is a revised filing memorandum reflecting the rates and rating plan of the Medical Indemnity Corporation of Alaska. We believe that the changes made in our filing of October 1, 1976 are responsive to your order 76-2 and look forward to receiving your approval.

If you have any questions, however, please feel free to contact me or our consulting actuaries, Milliman & Robertson.

Sincerely,



William G. Brock
Chairman

Enclosure

RECEIVED
NOV 2 6 1976
DEPARTMENT OF COMMERCE
& ECONOMIC DEVELOPMENT
DIV. OF INSURANCE

MEDICAL INDEMNITY CORPORATION OF ALASKA

AMENDED FILING MEMORANDUM

NOVEMBER 23, 1976

RECEIVED
NOV 26 1976
DEPARTMENT OF COMMERCE
& ECONOMIC DEVELOPMENT
DIV. OF INSURANCE

MEDICAL INDEMNITY CORPORATION OF ALASKA

AMENDED FILING MEMORANDUM

Background

On October 1, 1976 the Medical Indemnity Corporation of Alaska filed with the Director of Insurance a set of rates and rating plans with accompanying documentation for Physicians and Surgeons and Hospital Professional Liability Policy to be written by the MICA. After four days of public hearings concerning this filing, the Director, on October 21, issued an Order (Order 76-2) which disapproved the filing, calling attention to several characteristics of the proposed rating plans which appeared to be inequitable.

The purpose of this memorandum is to make the necessary amendments to the original MICA filing which will correct the deficiencies noted in the Director's Disapproval Order of October 21. There are additional changes proposed in this memorandum which, although not specifically mandated by the Director's Order, improve the overall equitability of the rating structure.

A summary of the amendments are as follows:

1. Revised Physicians and Surgeons Class Plan.
2. Revised exposure base for Physicians and Surgeons (gross receipts versus gross billings).
3. Urban and rural territories for Physicians and Surgeons.
4. Reduction in expense allowance for risk management.
5. Use of emergency room visits versus total outpatient visits as hospital exposure base.
6. Rates for excess limits.
7. Immediate implementation of 10% AGPA credit for clinics.
8. Rates for premises liability.

The details of the enclosed amendments are as follows:

Overall Rate Level

We are proposing the same overall rate level for both Physicians and Surgeons and Hospitals as was originally filed October 1. Our proposed average pure premium for 200/600 limits per physician per year remains at $4,450. The proposed average pure premium per occupied hospital bed for 200/1 million limits remains at $900. Brief summaries of the back-up information relating to these average pure premiums are repeated in this memorandum in Exhibits 1 and 2 (for Physicians and Surgeons) and Exhibit 11 (Hospitals).

Revised Class Plan

The Board of Directors of MICA is recommending some revisions in the propos Physicians and Surgeons class definitions. The revised class plan is shown in Exhibit 3. During the public hearings relating to the October 1st filing, extensive testimony was received relating to the possible inequity of the class plan as originally filed. This testimony, combined with the concern voiced by the Director in the Disapproval Order, influenced the Board, with the counsel of Milliman & Robertson, to re-examine the entire class plan question. Evidence was uncovered which justified several subdivisions of the originally recommended class definitions. Most significantly, we have recommended that class one be subdivided into class 1A and 1B. Statistical data from several large states, which subdivide their experience into individual specialties, provided strong justification for a special class 1A with a rate relativity no greater than 50% of the remainder of class 1. The states which provided such detailed breakdown were New York, New Jersey and California. It might be noted that the group plans in these states have made a subdivision in their rate schedule similar to that which we are recommending in this amended filing. In addition to the class 1 subdivision, we have noted that the most recent national data indicates

that the specialties of ophthalmology and urology should be placed in a lower category than was originally recommended. The recommended statewide class relativities for this new class structure are shown in Exhibit 4. These relativities are based on recently updated countrywide classification data. It can be noted in this Exhibit that this revised rate structure amounts simply to a re-allocation of the same statewide average pure premium of $4,450.

The Disapproval Order also suggested that the basic definitions of classes 1, 2, and 3 as originally filed be modified so that the distinction between these classes would be based strictly on whether the specialties engaged in no surgery, minor surgery or major surgery (Section 28 of the Order). After extensive deliberation among themselves and with many representatives of physicians throughout the State of Alaska, the MICA Board determined that they felt "that the Order and the rejection of our previous class definitions provide inconsistencies that cannot be resolved". Therefore they are resubmiting the class definitions as attached.

Revised exposure base

The original filing recommended an exposure base of gross billings, subdivided by professional charges and the ancillary charges. As mandated by the Disapproval Order, this amended filing discards that definition of exposure and substitutes for it annual gross receipts, with no distinction between professional charges and ancillary charges. Based on this revised exposure base, we have in Exhibit 5 determined first the proposed average statewide premium per doctor-year and translated this annual average premium to statewide rates per $1,000 gross receipts. The statewide rates are based on our best estimate of average gross receipts per specialty class. The fixed expense per doctor-year which is included in the rate formula is a reduction from the factor included in the original filing (which will be discussed later).

Territory Definitions

After extensive discussion with representatives of the physician community, the Board of MICA has elected to establish two rating territories for physicians and surgeons, as defined in Exhibit 6. They have, in addition, elected to establish a differential in the rate of 15% between the rural territory, Territory II, and the urban territory. Although no credible experience by rating territory exists in Alaska, there is ample precedent in many other states for making a territorial distinction in the professional liability rate level. In states such as Pennsylvania, Michigan, Illinois and New York, the typical relationship between rates (per doctor-year) for the non-urban area and the urban rates is about .6 to 1. Since there is also a likelihood that the average annual receipts in the rural area is less than that of the urban area, the Board has elected to make a differential of only 15% in the final gross rate per thousand dollars of gross receipts.

To allocate the statewide rate per $1,000 of gross receipts, we first estimated the distribution of exposures by class for the two rating territories and also determined the estimated average receipts per class by territory. These allocations are shown in Exhibit 7. The allocation of average receipts assumes that the average receipts in Territory II are 15% less than Territory I, by class. The final calculation of rates per thousand dollars receipts by territory is shown in Exhibit 8. We are proposing that a maximum annual premium be established for <u>each class</u> within each territory equal to 1.5 times the average annual rate. These proposed maximum annual premiums are shown in Columns 8 and 9 of Exhibit 8. We estimate that the overall premium on a receipts basis would be reduced 10 or 11% due to the effect of the individual maximum premiums per physician. This limitation requires an additional off-set factor of 1.12 which is applied uniformly to each class rate. The final

adjusted rates per $1,000 receipts, then, are shown in Columns 10 and 11 of Exhibit 8.

The proposed physicians and surgeons merit rating plan remains unchanged, and is shown in Exhibit 9.

Premises Liability for Physicians and Surgeons

Exhibit 10 includes a definition of the proposed exposure base for premises liability as well as a proposed rate of $7 per year per 100 square feet of area.

AGPA Credit

The MICA Board is now proposing that a 10% credit be given immediately to all medical clinics accredited by the American Group Practice Association.

Hospital Rates

As mentioned earlier, the overall rate level for hospitals remains unchanged. However, the MICA Board has elected to discard the original proposed rate based on total out-patient visits in favor of a rate per emergency room visit only. Since the total exposure base included in our analysis of hospital data included all out-patient visits, it is necessary to make a translation in our rate structure which will provide a rate per emergency room visit resulting in approximately the same overall premium dollars as was originally intended. Based on the most recent addition of Hospital Statistics, published by the American Hospital Association, the ratio of total out-patient visits to emergency room visits in Alaska is approximately 2.5 to 1. We have thus increased our original proposed rate for out-patient visits 2.5 times to apply to emergency room visits only. The modified rate structure for hospitals is shown in Exhibit 13. The rate per occupied bed is modified only slightly, due to a slight change in the expense constant.

To clarify our original filing, the data base on which we determined our projected pure premium per hospital bed included both hospital professional

liability and premises liability. Thus, the recommended premiums for hospitals insured with MICA include the perils associated with premises liability. We have determined that it would probably not serve a useful purpose to attempt to segregate the rate for premises liability from the medical professional liability.

Expense Allowance

There have been some slight modifications in the proposed allowance for MICA expenses. The Board has elected to delete all budgetary allowance for risk management and safety engineering allocable to Physicians and Surgeons and to allow $25,000 per year for this function for Hospital Professional Liability. The amended allocation of expenses is shown in Exhibit 14. The reduction in risk management expenses for Physicians and Surgeons results in a revised fixed expense per exposure of $480. The revised fixed expense per hospital bed is $83. These modifications result in an overall average expense ratio of approximately 15%.

Excess Limit Factor Recommendations

In Exhibits 15 and 16, we have developed our recommended excess limit factors for limits higher than 200/600 for both physicians and hospitals. These factors would apply uniformly to all classes and territories. At this time, however, we are not recommending that the MICA consider writing limits in excess of 200/600 unless reinsurance is available for these excess layers and/or additional loan funds can be made available.

Miscellaneous

We would like to place special emphasis in this amended filing on the fact that the rates and rating plans recommended herein apply only to a MICA operation which is the mandatory and exclusive writer of professional liability in the State of Alaska. If, through litigation or other reasons, the mandatory and exclusive characteristic of the MICA were changed, then the rates recommended

in this filing would not be appropriate and a revised filing would be required.

We would like to re-emphasise some cautions that were stated in our original filing, namely that many of the factors which became part of the calculations of the final gross rates for MICA are based on rather sparse information, tempered with a great deal of the combined judgment of the Board of Directors of MICA and Milliman & Robertson, Inc., and as such are subject to a wide range of variability. Section 21.88.080(8) of the new Statute states that "rates for any policy year should be calculated to include the adjustment for actual experience of the corporation as developed for the preceeding four policy years". This has been interpreted to mean that not only would prospective rates be adjusted to include inadequacies or excesses in past rates overall, but that incorrect initial estimates of gross receipts by specialty, further subdivided by territory, can be corrected prospectively in subsequent years' rates.

The MICA Board has made a thorough re-analysis of its proposed rates and rate structure for Alaska, including several discussions with the physician community, all of which resulted in the amendments included herein. We respectfully request favourable consideration of these amendments.

David R. Bickerstaff
Fellow, Casualty Actuarial Society

November 23, 1976

MEDICAL INDEMNITY CORPORATION OF ALASKA

Estimated Policy Year 1976-1977 Physicians and Surgeons

Pure Premiums - $25/75 Limits - Class 1

Based on Insurance Services Office (ISO) Experience for

Five Western States and ISO Countrywide Experience

State[1]	25/75 Class 1 Pure Premium[1]
Arizona	$ 956
California	1,600
Nevada	910
Oregon	523
Washington	450
Average of five states	$ 888
Countrywide (excluding Colorado, Illinois, New York and Texas)	$ 572
Selected Alaska Class 1 Pure Premium	$ 783[2]

NOTES:

1. Since Alaska experience is very limited, these five western states were selected as being representative of current loss experience for the State of Alaska. These estimates were based on ISO data modified for M&R estimates of loss development and trend, except for California's estimate which was based on other data sources.

2. This estimate is the five-state average weighted 2/3's and the countrywide average weighted 1/3.

3. The pure premiums include losses plus allocated loss adjustment expense.

Exhibit 2

MEDICAL INDEMNITY CORPORATION OF ALASKA

Estimated Policy Year 1976-1977 Physicians and Surgeons

Average Pure Premiums - $200/600 Limits

1.	Physicians and surgeons pure premium 25/75 limits, ISO Class 1	$783
2.	Approximate ISO average class relativity in loss cost	2.5
3.	Increased limit increment 25/75 to 100/300	1.85
4.	Estimated average pure premium 100/300, (1) x (2) x (3)	$3,621
5.	Increased limit increment, 100/300 to 200/600	1.23
6.	Estimated average pure premium 200/600 (4) x (5), rounded	$4,450

Exhibit 3

MEDICAL INDEMNITY CORPORATION OF ALASKA

Physicians and Surgeons Class Definitions

Class 1: Physicians, no surgery, subdivided as follows:

Class 1A:
- Aerospace Medicine
- Aviation Medicine
- Hematology
- Neurology
- Pathology
- Physiatry
- Psychiatry, no E.C.T.
- Public Health

Class 1B:
- Administrative Medicine
- Adolescent Medicine
- Acupuncture
- Allergy
- Cardiology
- Critical Care Medicine
- Emergency Medicine
- Dermatology
- Dysmorphology
- Endrocrinology
- Epidemiology
- Gastroenterology
- Genetics
- Gerontology
- Immunology
- Infectious Disease
- Industrial Medicine
- Internal Medicine
- Neonatology
- Nephrology
- Nuclear Medicine
- Occupational Medicine
- Oncology
- Osteopathy
- Pediatrics
- Podiatry
- Proctology
- Psychiatry, with E.C.T.
- Pulmonary Disease
- Radiology, diagnostic
- Rheumatology
- Venereology

Class 2: General Practice and Family Practice, Minor Surgery or assisting in Major Surgery

Class 3: General Practice and Family Practice, Major Surgery
Ophthalmology

Class 4:

Class 4A: Urology

Class 4B: Anesthesiology

Class 5:
- Otology
- Otorhinolaryngology
- Surgery, abdominal
- Surgery, colon & rectum
- Surgery, general
- Surgery, pediatric
- Surgery, traumatic

Class 6:
- Gynecology
- Obstetrics
- Radiology, therapeutic
- Surgery, cardiovascular
- Surgery, hand
- Surgery, neurological
- Surgery, orthopedic
- Surgery, plastic & reconstructive
- Surgery, thoracic
- Surgery, vascular

MEDICAL INDEMNITY CORPORATION OF ALASKA

Recommended Physicians and Surgeons Class Relativities and Pure Premiums - $200/600 Limits

Statewide

Class	Estimated Percentage of Physicians	Proposed Class Relativity	Estimated Pure Premium Per Doctor-Year
1A	6%	.50	$ 884
1B	31	1.00	1,767
2	14	1.50	2,651
3	18	2.40	4,241
4A	2	2.80	4,948
4B	4	3.10	5,479
5	9	4.40	7,776
6	16	6.00	10,604
Weighted Average		2.518	4,450

MEDICAL INDEMNITY CORPORATION OF ALASKA

Statewide Rates Per

$1,000 Gross Receipts Per Physician

Class	(1) Statewide Estimated Average Gross Receipts	(2) Statewide Proposed Average Pure Premium Per Doctor-Year	(3) Proposed Fixed Expense Per Doctor-Year	(4) Proposed Average Statewide Premium Per Doctor-Year (2)+(3)÷.935	(5) Statewide Indicated Rate Per $1,000 Gross Receipts (4)÷(1)x$1,000
1A	$120,000	$ 884	$480	$ 1,459	$12.16
1B	120,000	1,767	480	2,403	20.03
2	115,000	2,651	480	3,349	29.12
3	115,000	4,241	480	5,049	43.91
4A	110,000	4,948	480	5,805	52.78
4B	110,000	5,479	480	6,373	57.94
5	165,000	7,776	480	8,830	53.51
6	175,000	10,604	480	11,855	67.74

Exhibit 5

MEDICAL INDEMNITY CORPORATION OF ALASKA

Territory Definitions

Physicians & Surgeons

Territory I: Anchorage Municipality and the Fairbanks North Star Borough

Territory II: Remainder of State

Exhibit 7

MEDICAL INDEMNITY CORPORATION OF ALASKA

Assumed Distribution of Exposures and Receipts by Territory

	(1)	(2)	(3)	(4)	(5)	(6)
	Exposure Distribution			Average Receipts		
Class	Territory I (Anchorage, Fairbanks)	Territory II (Remainder of State)	Total	Statewide	Territory I*	Territory II =(5)x.85
1A	.05	.01	.06	$120,000	$123,077	$104,615
1B	.24	.07	.31	120,000	124,207	105,576
2	.10	.04	.14	115,000	120,149	102,127
3	.14	.04	.18	115,000	118,966	101,121
4A	.015	.005	.02	110,000	114,286	97,143
4B	.035	.005	.04	110,000	112,102	95,287
5	.07	.02	.09	165,000	170,690	145,086
6	.13	.03	.16	175,000	180,064	153,055
Total	.78	.22	1.00			

$$\text{* col (5)} = \frac{\text{Col(4)xCol(3)}}{\text{Col(1)+.85xCol(2)}}$$

Note: Average receipts in Territory II estimated to be 85% of Territory I, by class.

MEDICAL INDEMNITY CORPORATION OF ALASKA

Final Proposed Rates per $1,000 Gross Receipts Per Physician

By Territory

	(1)	(2)	(3)	(4)	(5)
		Exposure Distribution		Unadjusted Rate Per $1,000 Receipts	
Class	Statewide average rate (before Max.)	Territory I	Territory II	Territory I*	Territory II =.85x(4)
1A	$12.16	.05	.01	$12 43	$10.57
1B	20.03	.24	.07	20.65	17.55
2	29.12	.10	.04	30.27	25.73
3	43.91	.14	.04	45.24	38.45
4A	52.78	.015	.005	54.59	46.40
4B	57.94	.035	.005	58.90	50.06
5	53.51	.07	.02	55.13	46.86
6	67.74	.13	.03	69.45	59.03

* Col. (4) = $\text{Col}(1)\,\dfrac{\{\text{Col}(2)+.85\times\text{Col}(3)\}}{\{\text{Col}(2)+(.85)^2\times\text{Col}(3)\}}$

MEDICAL INDEMNITY CORPORATION OF ALASKA

Final Proposed Rates per $1,000 Gross Receipts Per Physician

By Territory

	(6)	(7)	(8)	(9)	(10)	(11)
	Average Receipts		Maximum Premium		Final proposed rate per $1,000 receipts, adjusted for Max.	
Class	Territory I	Territory II	Territory I*	Territory II**	Territory I =(4)x1.12	Territory II =(5)x1.12
1A	$123,077	$104,615	2,295	1,659	$13.90	$11.80
1B	124,207	105,576	3,847	2,779	23.10	19.70
2	120,149	102,127	5,455	4,637	33.90	28.80
3	118,966	101,121	8,073	5,832	50.70	43.10
4A	114,286	97,143	9,358	6,761	61.10	52.00
4B	112,102	95,287	9,904	7,155	66.00	56.10
5	170,690	145,086	14,115	10,198	61.70	52.50
6	180,064	153,055	18,758	13,552	77.80	66.10

* Col (4) $\times \frac{\text{Col (6)}}{1000} \times 1.5$

** Col (5) $\times \frac{\text{Col (7)}}{1000} \times 1.5$

MEDICAL INDEMNITY CORPORATION OF ALASKA

Physicians and Surgeons Merit Rating Plan

Merit Rating Plan

A surcharge will be applied to a physician's or surgeon's rate for claims during a four year period ending 30 days prior to the effective date of the policy as follows:

(1) Paid or Closed Claim in excess of $10,000 - 1 point per claim

(2) Filed or Pending Claim - 1 point per claim less 1 point

(3) Total Points (1) + (2) above

Points	Surcharge
1	10%
2	35%
3	85%
More than 3	50% surcharge per additional point

A claim will be counted only once for surcharging purposes and will be counted for no longer than four years. Claims which are determined to be patently frivolous will not be counted in any case.

The maximum annual premium limit will be imposed on the basic premium before applying surcharges, but the final surcharged premium will not be subject to any overall maximum.

MEDICAL INDEMNITY CORPORATION OF ALASKA

Proposed Rates for Premises Liability

Physicians and Surgeons 200/600 Limits

I. Exposure base: Area, as defined as follows

The word "area" means the total number of square feet of space of the insured premises except as otherwise specified in classification footnotes and shall be computed

1. For entire buildings, by multiplying the product of the horizontal dimensions of the outside of the outer building walls by the number of floors including basements. The area of the following shall be subtracted from the total number of square feet so computed

   (i) Courts and mezzanine type floor openings,

   (ii) Portions of basements or floors on which 50% or more of the area is used for shop or storage in connection with building maintenance, dwelling by building maintenance employees, heating units, power plants or air-conditioning equipment.

   (iii) Separate roof structures used exclusively for housing stairwells, stairways, or elevator, air-conditioning or other ventilating machinery and equipment.

   (iv) Private residences.

2. For tenants of entire floors above the grade floor, the area shall be computed in the manner described under subdivision 1. above. No deductions shall be made for public hallways, washrooms, elevator shafts, air shafts or stairwells even though such space is not rented by the insured.

3. For tenants of parts of floors or of entire grade floors or basements, the area shall be computed in the manner described under subdivision 1. above, except that the area shall be computed on the horizontal dimensions of the premises to be insured, inside the walls forming the boundary of the premises.

It shall not be permissible to exclude coverage for premises used for storage or other purposes which do not permit admission of the general public, or premises occupied by concessionaires.

In measuring dimensions for the calculation of area any fraction of a foot less than six inches shall be disregarded, any fraction of a foot six inches or greater shall be considered as an additional foot.

The unit of exposure to which the rates are applied is each 100 square feet of area.

II. Rate: $7.00 per year per 100 square feet of area.

MEDICAL INDEMNITY CORPORATION OF ALASKA

Estimated Accident Year 1976 Hospital Professional Liability Pure Premiums* - $25/75 Limits

Based on Countrywide Experience

Accident Year	(1) Total bed-years	(2) Estimated ultimate claim count	(3) Est. Ultimate frequency per bed-year	(4) Line of best fit for frequency	(5) Est. Ultimate average cost per claim 25/75 limit	(6) Est. Ultimate avg. cost per claim unlimited basis	(7) Line of best fit for avg. cost	(8) Avg. cost projection limited to 25/75	(9) Pure premium projection =(4)x(8)
1968	64,922	1,400	.02156	.02071	$2,047	$2,710	$ 2,648		
1969	79,554	1,665	.02093	.02244	2,825	4,090	3,599		
1970	99,232	2,309	.02327	.02432	3,100	4,600	4,891		
1971	122,070	3,245	.02658	.02635	3,780	6,060	6,647		
1972	128,727	3,979	.03091	.02856	4,650	8,070	9,034		
1973	139,005	4,762	.03426	.03095	5,925	11,915	12,277		
1974	133,795	3,998	.02988	.03353	7,750	19,300	16,686		
1975				(.03634)			(22,677)	(8,450)	$ 307
1976				(.03938)			(30,819)	(9,800)	$ 386

* includes premises liability loss experience

Exhibit 11

MEDICAL INDEMNITY CORPORATION OF ALASKA

Hospital Professional Liability Class Definitions

Class 1: Hospitals

Class 2: Mental-Retardation Institutions

Class 3: Mental-Psychopathic Institutions

Class 4: Convalescent or Nursing Homes

MEDICAL INDEMNITY CORPORATION OF ALASKA

Proposed Rates - Hospital Professional & Premises Liability - $200/1,000 Limits

A. Estimated Class 1 Rate Per Occupied Bed

(1)	Selected pure premium per occupied bed 25/75 limits	$ 400
(2)	Increased limit increment 25/75 to 200/1,000	2.25
(3)	Estimated pure premium per occupied bed 200/1,000 limits (1) x (2)	$ 900
(4)	Estimated expenses per occupied bed	
	a. Fixed, per occupied bed	$ 83
	b. Variable	6.5%
(5)	Proposed rate p occupied bed 200/1,000 limits { (3) + (4a) } ÷ { 1.0-(4b) }	$1,051

B. Estimated Class 1 Rate Per Emergency Room Visit

()	Proposed rate per emergency room visit 200/1,000 limits (A5) x .25%	$ 2.63

C. Proposed Rates

	Per occupied bed	Per E/R visit
Class 1	$1,051	$2.63
Class 2	526	1.31
Class 3	526	1.31
Class 4	210	.53

Notes:

1. The minimum limit is $200,000/$1,000,000. The aggregate is increased an additional $20,000 for each bed over 50.

2. The rates for outpatient visits and classes 2 - 4 were based on countrywide relativities to the basic class (hospital beds). Each rate was selected as a percentage of class 1 rates. The percentages chosen were 50% for classes 2 and 3, and 20% for class 4.

MEDICAL INDEMNITY CORPORATION OF ALASKA

Exhibit 14

Provision For Expenses[1] - Physicians And Surgeons And

Hospital Professional Liability

	(1) Physicians and Surgeons	(2) Hospital Professional Liability	(3) Total (1)+ (2)
A. FIXED EXPENSE[2]			
(1) Underwriting	$110,000	$10,000	$ 120,000
(2) Safety Engineering	0	25,000	25,000
(3) Other Expense[3]	85,000	15,000	100,000
(4) Subtotal (1)+(2)+(3)	195,000	50,000	245,000
(5) Adjusted Subtotal	180,000[4]	50,000	230,000
(6) Estimated Exposure	375[5]	600[6]	—
(7) Fixed Expense Per Exposure (5)÷(6)	480	83	—
B. VARIABLE EXPENSE[2]			
(1) Unallocated Loss Adjustment Expense	3.0%	3.0%	—
(2) Taxes	1.5%	1.5%	—
(3) Service Fee	2.0%	2.0%	—
(4) Total (1)+(2)+(3)	6.5%	6.5%	—
C. AVERAGE PERMISSIBLE LOSS AND ALLOCATED LOSS ADJUSTMENT EXPENSE RATIO			
(1)	.844	.856	

NOTES:

1. Allocated Loss Adjustment Expenses are included with losses and are therefore excluded from these expenses.
2. Fixed Expense is a fixed charge per exposure; variable expense varies with written premium.
3. Other expense includes insurance, governors' fees and travel expenses, legal, actuarial and auditing fees and examination costs. .
4. We estimate that approximately 150 Physicians will pay minimum premiums of of $100. This $15,000 will be used to offset total fixed expenses as follows: $195,000 - $15,000 = $180,000
5. Excludes estimated number of physicians who will pay minimum premiums.
6. This number represents the number of equivalent occupied hospital beds (class 1) based on estimates of total beds and outpatient visits for all classes.

MEDICAL INDEMNITY CORPORATION OF ALASKA

Proposed Increased Limit Factor

Physicians and Surgeons

Policy Limit	(1) Statewide Average pure premium	(2) Expense constant	(3) Statewide Average gross annual rate = (1)+(2) / .935	(4) Relativity to 200/600
200/600	4,450	480	5,273	1.000
500/1000	5,766	480	6,680	1.267
1000/3000	6,544	480	7,512	1.425

MEDICAL INDEMNITY CORPORATION OF ALASKA

Proposed Increased Limit Factors

Hospitals

Policy Limits	(1) Average pure premium	(2) Expense constant	(3) Average gross annual rate $= \frac{(1)+(2)}{.935}$	(4) Relativity to 200/600
200/100	900	83	1,051	1.000
500/1500	1,166	83	1,336	1.271
1000/3000	1,324	83	1,505	1.431

COMMITTEE REPORT

SENATE

5/23/77

________________ Date

Mr. President:

The Committee on FINANCE has had SB 326
malpractice insurance coverage
under consideration. A majority of the members of the Committee

/_7 recommends it do pass

/_7 recommends it do not pass

/_7 recommends it do pass with attached amendment(s)

/_7 recommends it be replaced with CS for ________ and that CS for ________ do pass

/_7 (and) recommends it be referred to the ________ committee

/_7 reports it back without recommendation

/_7 AND attaches a report of its intent

/_7 (other) ________

MEMBERS SIGNING THE MAJORITY REPORT:

[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	[illegible]
[illegible]	[illegible]	

MEMBERS NOT CONCURRING IN THE MAJORITY REPORT:

________ recommends: ________

________ recommends: ________

________ recommends: ________

________ Chairman

S 60

COMMITTEE REPORT

5/19/77

SENATE

May [illegible] Date

Mr. President:

The Committee on FINANCE has had SB 326 malpractice insurance coverage under consideration. A majority of the members of the Committee

/_7 recommends it do pass

/_7 recommends it do not pass

/_7 recommends it do pass with attached amendment(s)

/_7 recommends it be replaced with CS for ______ and that CS for ______ do pass

/_7 (and) recommends it be referred to the ______ committee

/_7 reports it back without recommendation

/_7 AND attaches a report of its intent

/_7 (other) ______

MEMBERS SIGNING THE MAJORITY REPORT:

[illegible signatures]

Chm Tillman Do Pass

MEMBERS NOT CONCURRING IN THE MAJORITY REPORT:

______ recommends: ______

______ recommends: ______

______ recommends: ______

[signature] Chairman