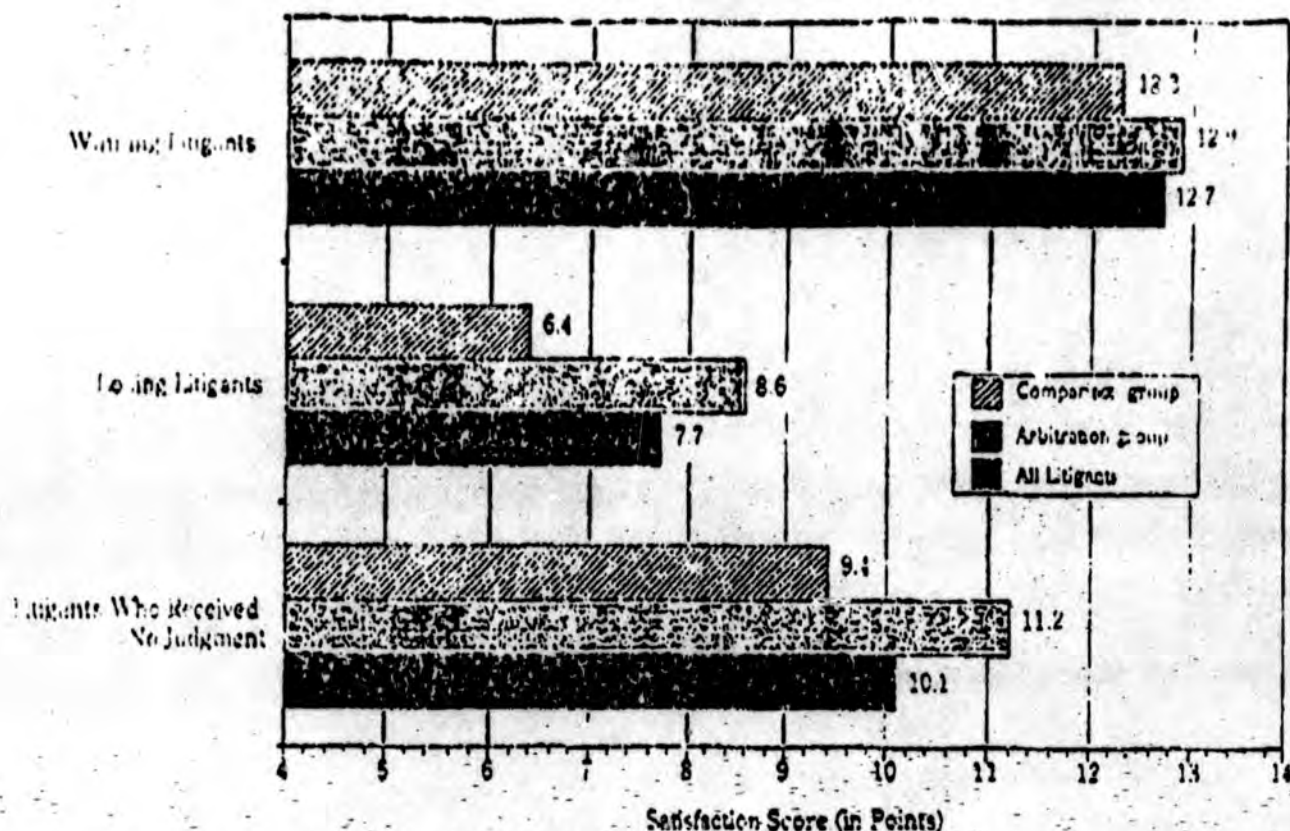


ALASKA LEGISLATURE SPECIAL COMMITTEE / SUBJECT FILE 8672
1725 SCOMM 69: HOUSE LIABILITY INSURANCE TASK FORCE, 1989-1990

1293

Figure 22. Mean Satisfaction Score for Winning and Losing Litigants



resulted in out-of-court settlements.⁶⁸ It seems reasonable to expect that, in terms of satisfaction, in most cases a settlement would be somewhere between winning and losing.

To assess the importance of winning and losing and other factors that could contribute to overall satisfaction, we performed a regression analysis.⁶⁹ It indicated that by far the most important determinant of overall satisfaction was winning or losing; the other factors considered had little or no effect on overall satisfaction once the procedure followed (arbitration or standard procedure) was taken into account.

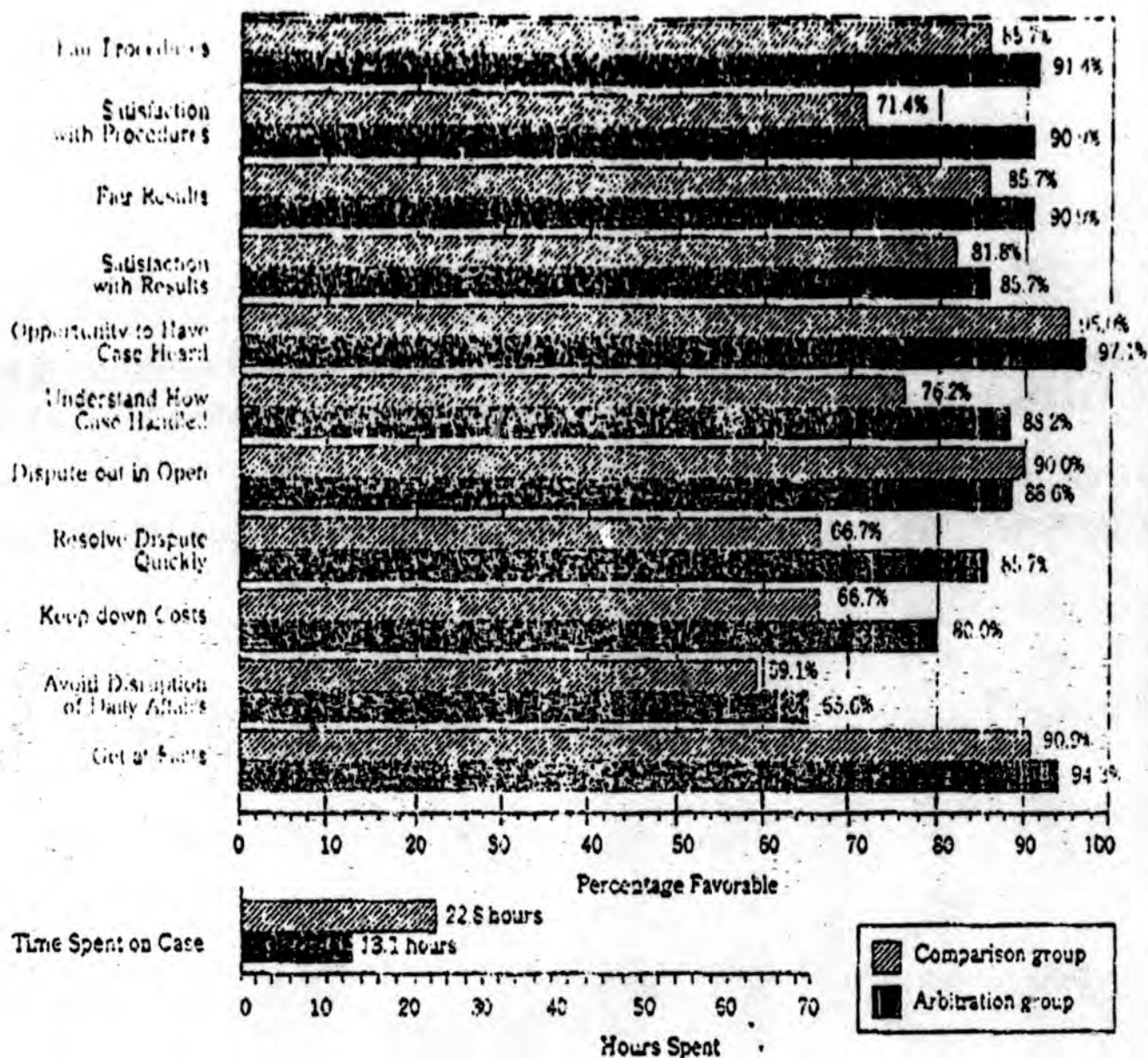
As shown in Figure 22, the mean overall satisfaction score was 7.7 for the forty-three losing litigants in the arbitration and comparison groups, 12.7 for the fifty-seven winning litigants, and 10.1 for the sixty-three litigants who received no judgment (most of the last group probably settled out of court). Thus, in terms of this score, winners were about 64 percent more satisfied than were losers, while those who (presumably) settled were about halfway between losers and winners.

The program evidently had different effects on the satisfaction of winners, losers, and those who settled. With respect to winners, the mean satisfaction score was 12.9 for the arbitration group and almost the same—12.3—for the comparison

68. See chapter two.

69. It was possible that other factors could interact with the arbitration program in influencing litigant satisfaction—that is, that the presence or absence of other factors could account for the program's apparent effect on litigant satisfaction. To test for this possibility, we formed four stepwise logit regression models of litigant satisfaction—one for each of the following questions concerning satisfaction: fairness of procedure, satisfaction with procedure, fairness of outcome, and satisfaction with outcome. (In each model the dependent variable was the logit—the logarithm of the odds of responding favorably

Figure 23. Responses of Winning and Losing Litigants to Twelve Evaluative Questions
a. Winning Litigants

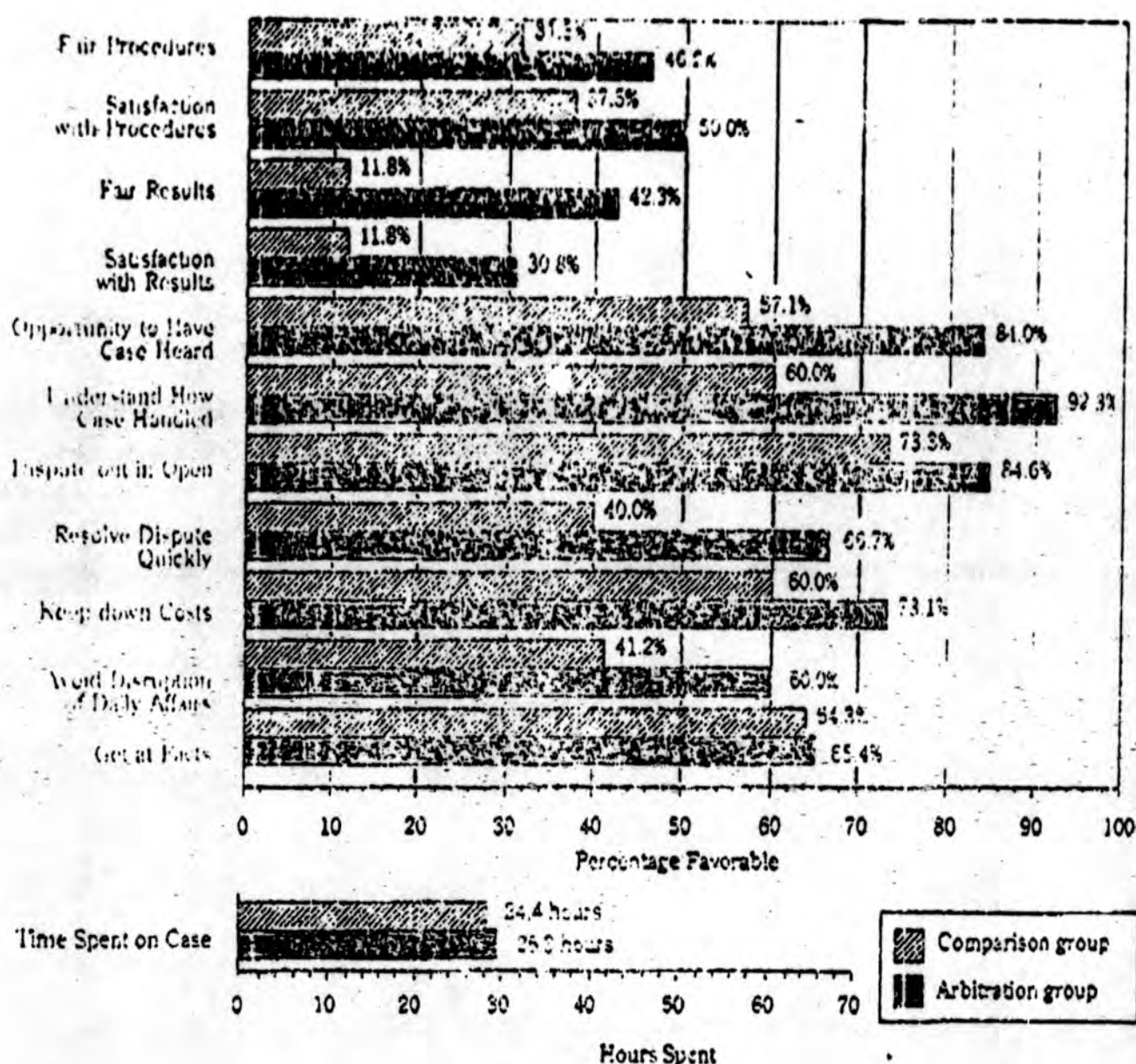


question arises from the following speculation. If the arbitration program had tended to lead to compromises of issues to a greater extent than standard procedure did, then losing defendants would have lost less, and winning plaintiffs would have won less. If this had occurred, it could explain why losing litigants (who were predominantly defendants) were more satisfied with the program than with standard litigation.⁷¹ In other words, losers' satisfaction could have increased not because of the program's procedural design but because the design promoted compromise.

In the analysis of court record data (see chapter five), we found no difference between the three groups—arbitration, control, and preprogram—in the percentage recovered by the plaintiff. This analysis was limited to contested cases ending in judgment (we had no data on out-of-court settlement amounts). But the cases whose

71. However, in this case it would be difficult to explain how winners who won less were nevertheless as satisfied with the arbitration program as with standard procedure.

Figure 23. Responses of Winning and Losing Litigants to Twelve Evaluative Questions
b. Losing Litigants



litigants we succeeded in interviewing were not necessarily the same cases as those for which we collected record court data.

For the cases in our interview samples, we computed the percentage of plaintiffs' claims recovered by judgment⁷² in each case that ended in a judgment. For losing defendants interviewed, the percentage of plaintiffs' claims that defendants lost averaged 86.2 percent in the arbitration group and 92.1 percent in the comparison group—a small, and not significant, difference. For winning plaintiffs interviewed, the percentage of their claims won averaged 69.6 percent in the arbitration group and 91.0 percent in the comparison group—again a negligible difference.⁷³

72. Note that our analysis of the amount recovered by the plaintiff is incomplete in that it does not include out-of-court settlements.

73. We also examined the percentage recovered by the plaintiff in cases where we interviewed (a) plaintiffs who lost and (b) defendants who won. The numbers in these two categories were very small because most interviewed plaintiffs won and most interviewed defendants lost. In both of these categories



ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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

November 7, 1988

MEMORANDUM

TO:

ATTN:

FROM: Patricia Young
Legislative Analyst

RE: Virginia Birth-Related Neurological Injury Compensation Act
Research Request 89.077

You asked for information about the Virginia Birth-Related Neurological Injury Compensation Act. According to Representative Clifton Woodrum, bill sponsor, this legislation was proposed in response to the refusal of one of three major insurance carriers to provide liability insurance for physicians of obstetrics and gynecology (OB/GYN) practicing in Virginia in groups of fewer than ten.

Currently, there is a lively debate in many states, including Alaska, over whether the "insurance crisis" is genuine or a fabrication on the part of the insurance industry. Virginia's "Bad Baby Act," effective January, 1988, is one state's response to one aspect of the liability insurance crisis (see attached). This approach modifies many years of judicial experience and case law. Proponents and opponents alike will be watching this situation due to its potential impact. However, several years may pass before a sufficient number of cases have been processed to determine whether or not such legislation is justified.

Virginia's act limits the liability of physicians and hospitals for birth-related neurological injuries caused or aggravated by substandard care unless there is clear and convincing evidence that injuries were intentional or willfully caused.¹ This statute effects several changes in well-established, judicially created rules for determining civil liability and damages:

¹It is important to note that this statute covers only the most disabling and costly injuries. "Neurological injuries" are defined as injuries to the brain or spinal cord which render infants "permanently nonambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living" (Code of Virginia, 38.2-5001).

- The law places a statutory upper limit on the amount of damages an injured party can recover for acts of negligence, gross negligence, and recklessness.
- An injured party is allowed only a nonjudicial remedy for acts of negligence, gross negligence, and recklessness. The injured party is prohibited from seeking redress in the courts unless there is willful or intentional wrongdoing on the part of the physician and/or the hospital.
- "Preponderance of evidence" is the standard of proof generally required in civil liability cases; this law increases the standard of proof to "clear and convincing evidence," a standard generally reserved for cases with overriding public policy implications.

In the event of a birth-related neurological injury, the act provides that the Industrial Commission of Virginia will award compensation to the legal representative of the infant for the following items:

- actual medically necessary and reasonable expenses of medical and hospital, rehabilitative, residential and custodial care and service, special equipment or facilities, and related travel for which the infant has not received nor is entitled to receive reimbursement from some other source [38.2-5009 (1)];
- loss of earnings from the age of eighteen through the age of sixty-five, in the amount of fifty percent of the average weekly wage in the Commonwealth of workers in the private, nonfarm sector [38.2-5009 (3)]; and
- reasonable expenses incurred in connection with the filing of the claim, including reasonable attorneys' fees [38.2-5009 (4)].

The act stipulates that compensation is to be awarded from a fund governed by a governor-appointed board of directors and maintained by annual assessments of \$5,000 from each participating OB/GYN physician; up to \$150,000 from each participating hospital (based on \$50 per delivery for the year prior to participation, but not to exceed \$150,000 per hospital in any one twelve-month period); and \$250 from each nonparticipating physician licensed by, and practicing in, the Commonwealth. According to the statute, "if required to maintain the fund on an actuarially sound basis," liability insurance carriers will also contribute annual assessments not to exceed "one quarter of one percent of . . . net direct [liability] premiums written" [38.2-5020 (B)]. Carriers are entitled to recover their assessed costs through surcharges on future policies and/or rate increases. Physicians and hospitals will presumably pass on their assessed costs to patients.

November 7, 1988
Page 3

How compensation will be awarded is unclear and open to debate, and regulations implementing the statute have not been drafted. Some covered medical, rehabilitative, custodial, and equipment expenses would continue for the life of the injured, and actual costs for these expenses will vary over time. According to Representative Woodrum, the legal representative of the injured child would be required to petition the commission each year for out of pocket expenses; however, language in the statute suggests a lump sum award. Loss of earnings would occur 18 through 65 years in the future, and there appears to be disagreement regarding this award also. Representative Woodrum indicated that compensation for loss of earnings would not begin until the injured child had reached the age of eighteen and would continue only during the life of the injured. However, according to Larry Tarr, chief deputy commissioner, Virginia Industrial Commission, the award for loss of earnings would be a lump sum amount based on current wage averages.²

Since its proposal, the statute has been controversial: many physicians object to subsidization of OB/GYN practitioners; many consumers argue that this statute allows doctors and hospitals, under certain circumstances, to act in a negligent or reckless manner without fully compensating victims. The likely net effect of the law will be that no suits are brought against physicians or hospitals for birth-related neurological injuries. Controversy will continue, however, and law suits may arise over the current lack of administrative clarity. Steve Kaufmann, Virginia Division of Insurance, anticipates a move to repeal this statute. He also expects that the law may be challenged and, if necessary, appealed to the State Supreme Court.

I hope this information is useful to you. If you have questions, please call.

Attachment

²Bob Griffin, chief economist, Virginia Employment Commission, Bureau of Labor Statistics, indicated that \$371 was the 1987 average weekly wage of workers in the private, nonfarm sector. Based on the current average wage, a lump sum compensation for loss of earnings between the ages of 18 and 65 would be \$463,008. If wage inflation were calculated, this amount would be substantially higher.

CODE OF VIRGINIA

1950

1988 Cumulative Supplement

ANNOTATED

Prepared under the Supervision of
The Virginia Code Commission
BY
The Editorial Staff of the Publishers

Under the Direction of

**A. D. KOWALSKY, S. C. WILLARD, W. L. JACKSON,
P. R. ROANE, K. S. MAWYER, AND T. R. TROXELL**

RECEIVED

JUL 06 1988

LEGISLATIVE AFFAIRS
Reference Library



VOLUME 6A

1986 REPLACEMENT

*Annotated through South Eastern Reporter, 2d Series, through
Volume 364, page 832. For complete scope of annotations,
see preface in supplement to Volume 1.*

**Place in Pocket of Corresponding Volume of Main Set.
This Supersedes Previous Supplement, Which
May Be Retained for Reference Purposes.**

THE MICHIE COMPANY

Law Publishers

CHARLOTTESVILLE, VIRGINIA

CHAPTER 50.

VIRGINIA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ACT.

Sec.	Sec.
38.2-5000. Short title.	38.2-5010. Rehearing on Commission determination or award.
38.2-5001. Definitions.	38.2-5011. Conclusiveness of determination or award; appeal.
38.2-5002. Virginia Birth-Related Neurological Injury Compensation Program; exclusive remedy; exception.	38.2-5012. Enforcement, etc., of orders and awards.
38.2-5003. Industrial Commission authorized to hear and determine claims.	38.2-5013. Limitation on claims.
38.2-5004. Filing of claims; review by Board of Medicine; review by Department of Health; filing of responses.	38.2-5014. Scope.
38.2-5005. Tolling of statute of limitations.	38.2-5015. Birth-Related Neurological Injury Compensation Fund.
38.2-5006. Hearing; parties.	38.2-5016. Board of directors; appointment; vacancies; term.
38.2-5007. Interrogatories and depositions.	38.2-5017. Plan of operation.
38.2-5008. Determination of claims; presumption; finding of Industrial Commission binding on participants; medical advisory panel.	38.2-5018. Assessments to be held in restricted cash account.
38.2-5009. Commission awards for birth-related neurological injuries; notice of award.	38.2-5019. Initial assessments.
	38.2-5020. Annual assessments.
	38.2-5021. Actuarial investigation, valuations, gain/loss analysis; notice if assessments prove insufficient.

§ 38.2-5000. Short title. — The provisions of this chapter shall be known and may be cited as the Virginia Birth-Related Neurological Injury Compensation Act. (1987, c. 540.)

§ 38.2-5001. Definitions. — As used in this chapter:

"Birth-related neurological injury" means injury to the brain or spinal cord of an infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation in the immediate post-delivery period in a hospital which renders the infant permanently nonambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living. This definition shall apply to live births only.

"Claimant" means any person who files a claim pursuant to § 38.2-5004 for compensation for a birth-related neurological injury to an infant. Such claims may be filed by any legal representative on behalf of an injured infant; and, in the case of a deceased infant, the claim may be filed by an administrator, executor, or other legal representative.

"Commission" means the Industrial Commission of Virginia.

"Participating physician" means a physician licensed in Virginia to practice medicine, who practices obstetrics or performs obstetrical services either full or part time and who at the time of the injury (i) had in force an agreement with the Commissioner of Health or his designee, in a form prescribed by the Commissioner, whereby the physician agreed to participate in the development of a program to provide obstetrical care to patients eligible for Medical Assistance Services and to patients who are indigent, and upon approval of such program by the Commissioner of Health, to participate in its implementation, (ii) had in force an agreement with the State Board of Medicine whereby the physician agreed to submit to review by the Board of Medicine as required by subsection B of § 38.2-5004, and (iii) had paid the assessment required pursuant to this chapter for the year in which the injury occurred.

"Participating hospital" means a hospital licensed in Virginia which at the time of the injury (i) had in force an agreement with the Commissioner of

Health or his designee, in a form prescribed by the Commissioner, whereby the hospital agreed to participate in the development of a program to provide obstetrical care to patients eligible for Medical Assistance Services and to patients who are indigent, and upon approval of such program by the Commissioner of Health, to participate in its implementation, (ii) had in force an agreement with the State Department of Health whereby the hospital agreed to submit to review of its obstetrical service, as required by subsection C of § 38.2-5004, and (iii) had paid the assessment required pursuant to this chapter for the year in which the injury occurred.

"Program" means the Virginia Birth-Related Neurological Injury Compensation Program established by this chapter. (1987, c. 540.)

§ 38.2-5002. Virginia Birth-Related Neurological Injury Compensation Program; exclusive remedy; exception. — A. There is hereby established the Virginia Birth-Related Neurological Injury Compensation Program.

B. The rights and remedies herein granted to an infant on account of a birth-related neurological injury shall exclude all other rights and remedies of such infant, his personal representative, parents, dependents or next of kin, at common law or otherwise arising out of or related to a medical malpractice claim with respect to such injury.

C. Notwithstanding anything to the contrary in this section, a civil action shall not be foreclosed against a physician or a hospital where there is clear and convincing evidence that such physician or hospital intentionally or willfully caused or intended to cause a birth-related neurological injury, provided that such suit is filed prior to and in lieu of payment of an award under this chapter. Such suit shall be filed before the award of the Commission becomes conclusive and binding as provided for in § 38.2-5011. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5003. Industrial Commission authorized to hear and determine claims. — The Industrial Commission is authorized to hear and pass upon all claims filed pursuant to this chapter. The Commission may exercise the power and authority granted to it in Chapter 2 (§ 65.1-10 et seq.) of Title 65.1 as necessary to carry out the purposes of this chapter. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5004. Filing of claims; review by Board of Medicine; review by Department of Health; filing of responses. — A. 1. In all claims filed under this chapter, the claimant shall file with the Commission a petition, setting forth the following information:

- a. The name and address of the legal representative and the basis for his representation of the injured infant;
- b. The name and address of the injured infant;
- c. The name and address of any physician providing obstetrical services who was present at the birth and the name and address of the hospital at which the birth occurred;
- d. A description of the disability for which claim is made;
- e. The time and place where the injury occurred;
- f. A brief statement of the facts and circumstances surrounding the injury and giving rise to the claim;

g. All available relevant medical records relating to the person who allegedly suffered a birth-related neurological injury and an identification of any unavailable records known to the claimant and the reasons for their unavailability;

h. Appropriate assessments, evaluations, and prognoses and such other records and documents as are reasonably necessary for the determination of the amount of compensation to be paid to, or on behalf of, the injured infant on account of a birth-related neurological injury;

i. Documentation of expenses and services incurred to date, which indicates whether such expenses and services have been paid for, and if so, by whom; and

j. Documentation of any applicable private or governmental source of services or reimbursement relative to the alleged impairments.

2. The claimant shall furnish the Commission with as many copies of the petition as required for service upon the Program, any physician and hospital named in the petition, the Board of Medicine and the Department of Health, along with a fifteen dollar filing fee. Upon receipt of the petition the Commission shall immediately serve the Program by service upon the agent designated to accept service on behalf of the Program in the plan of operation by registered or certified mail, and shall mail copies of the petition to any physician and hospital named in the petition, the Board of Medicine and the Department of Health.

B. Upon receipt of the petition, the Board of Medicine shall evaluate the claim, and if it determines that there is reason to believe that the alleged injury resulted from, or was aggravated by, substandard care on the part of the physician, it shall take any appropriate action consistent with the authority granted to the Board in §§ 54-316 through 54-325.

C. Upon receipt of the petition, the Department of Health shall evaluate the claim, and if it determines that there is reason to believe that the alleged injury resulted from, or was aggravated by, substandard care on the part of the hospital at which the birth occurred, it shall take any appropriate action consistent with the authority granted to the Department of Health in Title 32.1.

D. The Program shall have thirty days from the date of service in which to file a response to the petition, and to submit relevant written information relating to the issue of whether the injury alleged is a birth-related neurological injury, within the meaning of this chapter. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5005. Tolling of statute of limitations. — The statute of limitations with respect to any civil action that may be brought by or on behalf of an injured infant allegedly arising out of or related to a birth-related injury shall be tolled by the filing of a claim in accordance with this section, and the time such claim is pending shall not be computed as part of the period within which such civil action may be brought. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5006. Hearing; parties. — A. Immediately after such petition has been received, the Commission shall set the date for a hearing, which shall be held no sooner than 45 days and no later than 120 days after the filing of a petition, and shall notify the parties thereto of the time and place of such hearing. The hearing shall be held in the city or county where the injury

occurred, or in a contiguous city or county, unless otherwise agreed to by the parties and authorized by the Commission.

B. The parties to the hearing required under this section shall include the claimant and the Program. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5007. **Interrogatories and depositions.** — Any party to a proceeding under this chapter may, upon application to the Commission setting forth the materiality of the evidence to be given, serve interrogatories or cause the depositions of witnesses residing within or without the Commonwealth to be taken, the costs to be taxed as expenses incurred in connection with the filing of a claim, in accordance with subdivision 2 of § 38.2-5009. Such depositions shall be taken after giving notice and in the manner prescribed by law, for depositions in actions at law, except that they shall be directed to the Commission, the Commissioner or the Deputy Commissioner before whom the proceedings may be pending. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5008. **Determination of claims; presumption; finding of Industrial Commission binding on participants; medical advisory panel.** — A. The Commission shall determine, on the basis of the evidence presented to it, the following issues:

1. Whether the injuries claimed are birth-related neurological injuries as defined in § 38.2-5001. A rebuttable presumption shall arise that the injury alleged is a birth-related neurological injury where it has been demonstrated, to the satisfaction of the Industrial Commission, that the infant has sustained a brain or spinal cord injury caused by oxygen deprivation or mechanical injury, and that the infant was thereby rendered permanently nonambulatory, aphasic and incontinent.

If either party disagrees with such presumption, that party shall have the burden of proving that the injuries alleged are not birth-related neurological injuries within the meaning of the chapter.

2. Whether obstetrical services were delivered by a participating physician at the birth.

3. Whether the birth occurred in a participating hospital.

4. How much compensation, if any, is awardable pursuant to § 38.2-5009.

5. If the Commission determines (i) that the injury alleged is not a birth-related neurological injury within the meaning of this chapter, (ii) that obstetrical services were not delivered by a participating physician at the birth, or (iii) that the birth did not occur in a participating hospital, it shall cause a copy of such determination to be sent immediately to the parties by registered or certified mail.

6. By becoming a participating physician or hospital each participant is bound for all purposes including any suit at law against a participating physician or participating hospital, by the finding of the Industrial Commission (or any appeal therefrom) with respect to whether such injury is birth-related.

B. The deans of the medical schools of the Commonwealth shall develop a plan whereby each claim filed with the Commission is reviewed by a panel of three qualified and impartial physicians. This panel shall file its report and recommendations as to whether the injury alleged is a birth-related neurological injury within the meaning of this chapter with the Commission at least

ten days prior to the date set for hearing pursuant to § 38.2-5006. At the request of the Commission, at least one member of the panel shall be available to testify at the hearing. The Commission must consider, but shall not be bound by, the recommendation of the panel. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5009. Commission awards for birth-related neurological injuries; notice of award. — Upon determining (i) that an infant has sustained a birth-related neurological injury, (ii) that obstetrical services were delivered by a participating physician at the birth, and (iii) that the birth occurred in a participating hospital, the Commission shall make an award providing compensation for the following items relative to such injury:

1. Actual medically necessary and reasonable expenses of medical and hospital, rehabilitative, residential and custodial care and service, special equipment or facilities, and related travel. However, such expenses shall not include:

a. Expenses for items or services that the infant has received, or is entitled to receive, under the laws of any state or the federal government except to the extent prohibited by federal law;

b. Expenses for items or services that the infant has received, or is contractually entitled to receive, from any prepaid health plan, health maintenance organization, or other private insuring entity;

c. Expenses for which the infant has received reimbursement, or for which the infant is entitled to receive reimbursement, under the laws of any state or federal government except to the extent prohibited by federal law; and

d. Expenses for which the infant has received reimbursement, or for which the infant is contractually entitled to receive reimbursement, pursuant to the provisions of any health or sickness insurance policy or other private insurance program.

2. Expenses of medical and hospital services under subdivision 1 of this section shall be limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living when such treatment is paid for by the injured person.

3. Loss of earnings from the age of eighteen. — An infant found to have sustained a birth-related neurological injury shall be conclusively presumed to have been able to earn income from work from the age of eighteen through the age of sixty-five, if he had not been injured, in the amount of fifty percent of the average weekly wage in the Commonwealth of workers in the private, nonfarm sector.

4. Reasonable expenses incurred in connection with the filing of a claim under this chapter, including reasonable attorneys' fees, which shall be subject to the approval and award of the Commission.

5. A copy of the award shall be sent immediately by registered or certified mail to the parties. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5010. Rehearing on Commission determination or award. — If an application for review is made to the Commission within twenty days from the date of a determination pursuant to subdivisions A 1 through A 3 of § 38.2-5008, or within twenty days from the date of an award by the Commission pursuant to § 38.2-5009, the full Commission, excluding any member of the Commission who made the determination or award, if the first

hearing was not held before the full Commission, shall review the evidence. If deemed advisable and as soon as practicable, the Commission instead may hear the parties, their representatives and witnesses and shall make a determination or award, as appropriate. Such review or determination, together with a statement of the findings of fact, rulings of law and other matters pertinent to the questions at issue, shall be filed with the record of the proceedings and shall be sent immediately to the parties. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5011. Conclusiveness of determination or award; appeal. — A. The determination of the Commission pursuant to subdivisions A 1 through A 3 of § 38.2-5008, or the award of the Commission, as provided in § 38.2-5009, if not reviewed in due time, or a determination or award of the Commission upon such review, as provided in § 38.2-5010, shall be conclusive and binding as to all questions of fact. No appeal shall be taken from the decision of one commissioner until a review of the case has been had before the full Commission, as provided in § 38.2-5010. Appeals shall lie from the full Commission to the Court of Appeals in the manner provided in the Rules of the Supreme Court.

B. The notice of appeal shall be filed with the clerk of the Commission within thirty days from the date of such determination or award or within thirty days after receipt by registered or certified mail of such determination or award. A copy of the notice of appeal shall be filed in the office of the clerk of the Court of Appeals as provided in the Rules of the Supreme Court.

C. Cases so appealed shall be placed upon the privileged docket of the Court and be heard at the next ensuing term thereof. In case of an appeal from an award of the Commission to the Court of Appeals, the appeal shall operate as a suspension of the award, and the Program shall not be required to make payment of the award involved in the appeal until the questions at issue therein shall have been fully determined in accordance with the provisions of this chapter. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5012. Enforcement, etc., of orders and awards. — The Commission has full authority to enforce its orders and protect itself from deception. While the language of this section is permissive and provides that a party may enforce an award in court, it must be read and considered in pari materia with the Commission's power pursuant to § 65.1-20 to punish for disobedience of its orders. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5013. Limitation on claims. — Any claim under this chapter that is filed more than ten years after the birth of an infant alleged to have a birth-related neurological injury is barred. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5014. Scope. — This chapter applies to all claims for birth-related neurological injuries occurring in this Commonwealth on and after January 1, 1988. The chapter shall not apply to disability or death caused by genetic or congenital abnormalities. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5015. Birth-Related Neurological Injury Compensation Fund. — There is established the Birth-Related Neurological Injury Compensation Fund to finance the Virginia Birth-Related Neurological Injury Compensation Program created by this chapter. (1987, c. 540.)

§ 38.2-5016. Board of directors; appointment; vacancies; term. — A. The Birth-Related Neurological Injury Compensation Program shall be governed by a board of five directors.

B. Directors shall be appointed for a term of three years or until their successors are appointed and have qualified.

C. 1. The directors shall be appointed by the Governor as follows:

- a. One citizen representative;
- b. One representative of participating physicians;
- c. One representative of participating hospitals;
- d. One representative of liability insurers; and
- e. One representative of physicians other than participating physicians.

2. The Governor may select the representative of the participating physicians from a list of at least three names to be recommended by the Virginia Society of Obstetrics and Gynecology; the representative of participating hospitals from a list of at least three names to be recommended by the Virginia Hospital Association; the representative of liability insurers from a list of at least three names, one of which is recommended by the American Insurance Association, one by the Alliance of American Insurers, and one by the National Association of Independent Insurers; and the representative of physicians other than participating physicians from a list of at least three names to be recommended by the Medical Society of Virginia. In no case shall the Governor be bound to make any appointment from among the nominees of the respective associations.

D. The Governor shall promptly notify the association, which may make nominations, of any vacancy other than by expiration among the members of the board representing a particular interest and like nominations may be made for the filling of the vacancy.

E. The directors shall act by majority vote with five directors constituting a quorum for the transaction of any business or the exercise of any power of the Program. The directors shall serve without salary, but each director shall be reimbursed for actual and necessary expenses incurred in the performance of his official duties as a director of the Program. The directors shall not be subject to any personal liability with respect to the administration of the Program.

F. The board established by this section shall have the power to (i) administer the Program, (ii) administer the Birth-Related Neurological Injury Compensation Fund, (iii) appoint a service company or companies to administer the payment of claims on behalf of the Program, (iv) direct the investment and reinvestment of any surplus in the Fund over losses and expenses, provided any investment income generated thereby remains in the Fund, and (v) reinsure the risks of the Fund in whole or in part. (1987, c. 540.)

§ 38.2-5017. Plan of operation. — A. On or before September 30, 1987, the directors of the Program shall submit to the State Corporation Commission for review a proposed plan of operation consistent with this chapter.

B. The plan of operation shall provide for the efficient administration of the Program and for the prompt processing of claims made against the Fund pursuant to an award under this chapter. The plan shall contain other provisions including:

1. Establishment of necessary facilities;
2. Management of the Fund;
3. Appointment of servicing carriers or other servicing arrangements to administer the processing of claims against the Fund;

1. Initial and annual assessment of the persons and entities listed in § 38.2-5019 to pay awards and expenses, which assessments shall be on an actuarially sound basis subject to the limits set forth in § 38.2-5019; and

5. Any other matters necessary for the efficient operation of the Program.

C. The plan of operation shall be subject to approval by the State Corporation Commission after consultation with representatives of interested individuals and organizations. If the State Corporation Commission disapproves all or any part of the proposed plan of operation, the directors shall within thirty days submit for review an appropriate revised plan of operation. If the directors fail to do so, the State Corporation Commission shall promulgate a plan of operation. The plan of operation approved or promulgated by the State Corporation Commission shall become effective and operational upon order of the State Corporation Commission.

D. Amendments to the plan of operation may be made by the directors of the Program, subject to the approval of the State Corporation Commission. (1987, c. 540.)

§ 38.2-5018. Assessments to be held in restricted cash account. — All assessments paid pursuant to the plan of operation, shall be held in a separate restricted cash account under the sole control of an independent fund manager to be selected by the directors. The Fund, and any income from it, shall be disbursed for the payment of awards as provided in this chapter and for the payment of the expenses of administration of the Fund. (1987, c. 540.)

§ 38.2-5019. Initial assessments. — A. On or before January 1, 1988, the following persons and entities shall pay into the Fund an initial assessment in accordance with the plan of operation:

1. Physicians who wish to participate in the Virginia Birth-Related Neurological Injury Compensation Program and who otherwise qualify as participating physicians under this chapter shall pay an initial assessment of \$5,000.

Any physician who is otherwise eligible to become a participating physician, but who did not meet the requirements of § 38.2-5001 on or before January 1, 1988, may become a participating physician by filing the agreements required by § 38.2-5001 and by paying an assessment to the Program on or before May 15, 1988. The amount of this assessment shall be determined by the Board of Directors of the Program on a prorated basis for the months remaining in 1988 at the time the assessment is paid. A physician who satisfies the conditions imposed by this paragraph shall be considered a participating physician in the Program for the remainder of 1988, beginning on the first day of the first month following the receipt by the Program of the required agreements and prorated assessment.

Physicians who are employed by the Commonwealth who wish to participate in the Program and who otherwise qualify as participating physicians may pay the assessment required by this subsection on or before July 31,

1988, provided they have notified the Program on or before January 1, 1988, of their desire to participate in the Program. Such participation shall become effective retroactive to January 1, 1988, at the time the assessment is received by the Program.

2. Hospitals which wish to participate in the Virginia Birth-Related Neurological Injury Program and that otherwise qualify as participating hospitals under this chapter shall pay an initial assessment of \$50 per delivery for the prior year, as reported to the Department of Health in the most recent annual licensure survey of hospitals, not to exceed \$150,000 per hospital in any one twelve-month period.

Any hospital which is otherwise eligible to become a participating hospital, but which did not meet the requirements of § 38.2-5001 on or before January 1, 1988, may become a participating hospital by filing the agreements required by § 38.2-5001 and by paying an assessment to the Program on or before May 15, 1988. The amount of the assessment shall be determined by the Board of Directors of the Program on a prorated basis for the months remaining in 1988 at the time the assessment is paid. A hospital satisfying the conditions imposed by this paragraph shall be considered a participating hospital in the Program for the remainder of 1988, beginning on the first day of the first month following the receipt by the Program of the required agreements and prorated assessment.

State hospitals which wish to participate in the Program and which otherwise qualify as participating hospitals may pay the assessment required by this subsection on or before July 31, 1988, provided they have notified the Program on or before January 1, 1988, of their desire to participate. Such participation shall become effective retroactive to January 1, 1988, at the time the assessment is received by the Program.

3. All physicians licensed by and practicing in the Commonwealth as of September 30, 1987, other than participating physicians, shall pay into the Fund an initial assessment of \$250, in the manner required by the plan of operation.

B. Upon so certifying to the Program, any physician who comes within one of the following categories shall be exempt from paying the initial and annual assessments imposed upon physicians other than participating physicians pursuant to this chapter:

1. A physician who is employed by the Commonwealth and whose income from professional fees is less than an amount equal to ten percent of his annual salary.

2. A physician who is enrolled in a full-time graduate medical education program accredited by the American Council for Graduate Medical Education.

3. A physician who has retired from active clinical practice. (1987, c. 540; 1988, c. 164.)

The 1988 amendment, effective March 20, 1988, added the second paragraph of subdivision A 1 and added the second paragraph of subdivision A 2.

§ 38.2-5020. Annual assessments. — A. Beginning January 1, 1939, the persons and entities listed in subdivisions 1 through 3 of subsection A of § 38.2-5019, as of the date determined in accordance with the plan of operation, shall pay an annual assessment in the amount equal to their initial assessments, in the manner required by the plan of operation.

B. Taking into account the assessments collected pursuant to subsection A of this section, if required to maintain the Fund on an actuarially sound basis, all insurance carriers licensed to write and engaged in writing liability insurance in the Commonwealth as of September 30, 1988, shall pay into the Fund an annual assessment, in an amount determined by the State

Corporation Commission pursuant to subsection A of § 38.2-5021, in the manner required by the plan of operation. Liability insurance for the purposes of this provision shall include the classes of insurance defined in §§ 38.2-117 through 38.2-119 and the liability portions of the insurance defined in §§ 38.2-124, 38.2-125 and 38.2-130 through 38.2-132.

1. All annual assessments against liability insurance carriers shall be made on the basis of net direct premiums written for the business activity which forms the basis for each such entity's inclusion as a funding source for the Program in the Commonwealth during the prior year ending December 31, as reported to the State Corporation Commission, and shall be in the proportion that the net direct premiums written by each on account of the business activity forming the basis for their inclusion in the Program bears to the aggregate net direct premiums for all such business activity written in this Commonwealth by all such entities. For purposes of this chapter "net direct premiums written" means gross direct premiums written in this Commonwealth on all policies of liability insurance less (i) all return premiums on the policy, (ii) dividends paid or credited to policyholders, and (iii) the unused or unabsorbed portions of premium deposits on liability insurance.

2. The entities listed in this subsection shall not be individually liable for an annual assessment in excess of one quarter of one percent of that entity's net direct premiums written.

3. Liability insurance carriers shall be entitled to recover their initial and annual assessments through (i) a surcharge on future policies, (ii) a rate increase applicable prospectively, or (iii) a combination of the two, at the discretion of the State Corporation Commission. (1987, c. 540.)

§ 38.2-5021. Actuarial investigation, valuations, gain/loss analysis; notice if assessments prove insufficient. — A. The Bureau of Insurance of the State Corporation Commission shall undertake an actuarial investigation of the requirements of the Fund based on the Fund's experience in the first year of operation, including without limitation the assets and liabilities of the Fund. Pursuant to such investigation, the State Corporation Commission shall establish the rate of contribution of the entities listed in subsection B of § 38.2-5020 for the tax year beginning January 1, 1989.

Following the initial valuation, the State Corporation Commission shall cause an actuarial valuation to be made of the assets and liabilities of the Fund no less frequently than biennially. Pursuant to the results of such valuations, the State Corporation Commission shall prepare a statement as to the contribution rate applicable to contributors listed in subsection B of § 38.2-5020. However, at no time shall the rate be greater than one quarter of one percent of net direct premiums written.

B. In the event that the State Corporation Commission finds that the Fund cannot be maintained on an actuarially sound basis subject to the maximum assessments listed in §§ 38.2-5019 and 38.2-5020, the Commission shall promptly notify the Speaker of the House of Delegates, the President of the Senate, and the Industrial Commission. (1987, c. 540.)



**ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY**

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

February 14, 1989

MEMORANDUM

TO:

ATTN:

FROM: Patricia Young *PM*
Legislative Analyst

RE: Virginia Birth-Related Neurological Injury Compensation Act
Research Request 89.077 (Supplemental Information)

After receiving the memorandum describing the Virginia Birth-Related Neurological Injury Compensation Act, you asked for information on changes in insurance premium rates for physicians and consumers resulting from passage of the act. You also requested information on solutions proposed by other states for dealing with this aspect of liability insurance. In addition, you asked for comments on whether or not a similar act would improve the liability insurance situation in Alaska.

Virginia's Birth-Related Neurological Injury Compensation Act--Results

Since the Virginia statute's effective date of January 1, 1988, no claims for compensation have been made. According to Bob Miller, deputy commissioner of regulation, Virginia Division of Insurance, passage of the act has resulted in a premium discount of approximately ten percent for participating obstetricians. If removing catastrophically damaged children from the tort system reduces costs, then premiums will probably decrease more significantly. Such decreases would not occur immediately, however, because insurers are still responsible for babies injured prior to the effective date. Furthermore, whether or not costs will be reduced is uncertain. The Virginia Legislature estimated that 40 children per year would meet the criteria for compensation. An actuarial firm estimated the cost per child at \$500,000. Based on the estimate of 40 children, projected revenues of \$14 million would fall short of the \$20 million in costs. The shortfall could be far greater, however, because the actuarial analysis did not take into account the loss of earnings provision.

According to Ken Heland, associate director of the American College of Obstetricians and Gynecologists and head of the Department of Professional Liability, the statute is too strict in its definitions. He indicated, for example, that the significance of birth-related asphyxia is a topic of controversy currently raging among pediatric experts. Medical evidence increasingly suggests that asphyxia is only a very minor contributor to major birth-related problems. In addition, conditions of permanency can take several years to determine. Eligibility so narrowly defined, according to Mr. Heland, will significantly postpone or deter claims under the compensation act.

Although the law has not been challenged, it raises some constitutional questions. Under Virginia statute, an obstetrician's participation in the plan is optional. If an obstetrician chooses to participate, the injured party's exclusive remedy for damages--unless there is clear and convincing evidence that injuries were intentional or willfully caused--is limited to the benefits provided under the plan. An argument could be made that subjecting a patient to such a variable violates legal rights to equal protection, access to courts, and trial by jury.

Legislation in Other States

Florida is the only other state with legislation addressing birth-related neurological injuries. The statute, which is based on Virginia's and is very similar to it, was enacted in a special session in February 1988, and went into effect January 1, 1989. Pamela Burch Fort, staff director of the Florida Senate Committee on Insurance, noted that although the Florida Medical Association was the only supporters of the bill, dissenting members have now filed suit against it, claiming unconstitutionality.

Although malpractice liability insurance for obstetricians was more readily available in Florida than in Virginia, Florida obstetricians supported the law as a means to reduce premiums. Ms. Burch Fort indicated that the number of infants who qualify under the plan has not been determined. Estimates range from 60--based on a closed-claim study--to 376 per year. The variation is due to difficulties arising from eligibility definitions. The committee has concluded, however, that a permanent and total disability claim on a present value basis would total approximately \$1 million. Less severe claims or less

February 14, 1989

Page 3

than total disability would represent a cost of approximately \$400,000. The cost of 60 claims might conservatively total \$45 million per year. On a fully funded basis, program assessments would total only \$22 million per year--far short of the most conservative estimated need. The committee further noted that closed-claim studies do not reflect birth-related neurological injuries which have not been litigated. The committee assumes, therefore, that the frequency of claims will probably increase under the compensation plan. Thus, whether or not costs, and therefore premiums, will be reduced is uncertain.

Other states have proposed or established no-fault systems of compensation for medical injuries, but according to Mr. Heland, only those in Virginia and Florida deal specifically with birth-related neurological injuries.¹

Efficacy of a Birth-Related Neurological Injury Compensation Act in Alaska

Questions of constitutionality and other problems associated with both Virginia's and Florida's compensation programs--and uncertainty about whether or not costs will be reduced--diminish the possibility that a similar statute in Alaska would benefit physicians or consumers. Removal of catastrophically injured babies from the tort system of remedies might reduce premiums if the difficulties--including the problem of determining permanent birth-related neurological injuries--could be overcome. As Mr. Heland put it, "the idea might be a good one if it were debugged and improved upon." Jan Johnson, claims manager of the Medical Indemnity Corporation of Alaska, concurred and noted that a no-fault compensation program which provides a lump sum award is both more costly and less effective than a structured settlement or annuity which provides periodic payments for true medical and care needs and for lost income. Neither recommended implementation of a statute similar to Virginia's or Florida's.

I hope that this information is of use to you. Please call me if you have questions or need further information.

¹In Montgomery County, Maryland, obstetricians are considered part-time county employees and are covered by the county's liability insurance when treating patients referred by the county. Physicians are covered by their own insurance when treating private patients. This program helps assure access to care for the medically indigent--patients who are frequently more high risk due to lack of prenatal care. The program works, according to Ken Heland, because babies delivered for county patients are not counted in per delivery premium calculations. Mr. Heland commented that unless a state implements a similar system, premiums would probably not decline.

SCOMM

69:B8

#8

ROLES AND MECHANISMS OF STATE AGENCIES

- 1) Overview of Functions: Division of Insurance
- 2) Letter: 01/17/1989 To: John Andrews From: Donald Hitchcock
- 3) Functions of Division of Risk Management
- 4) Division of Occupational Licensing - FY 89 Performance Report

TI
#8

ROLES AND MECHANISMS
OF
STATE AGENCIES

DIVISION OF INSURANCE

OVERVIEW OF FUNCTIONS

Market Conduct Surveillance

The functions of this section are to review all rate and form filings submitted by insurance companies and to perform market conduct examinations on insurance companies or producer licensees to ensure that the consumer is treated fairly in the insurance marketplace.

Form filings refer to the process in which all forms which make up an insurance contract must be filed with, and approved by, the division before they can be used in the marketplace by an insurer. Division staff are required to determine if the filing is in compliance with specific statutory provisions and/or does not contain provisions which are ambiguous, misleading, inconsistent, or deceptively affects the risk purportedly covered. Generally, the division has 30 days in which to disapprove a filing or it is deemed approved. However, a form may be disapproved at a later date by an order of the director which may be appealed through an administrative hearing requested by the affected insurer and possibly, ultimately, by appeal to the court. (The appeal process is also available for a disapproval that takes place initially.) Literally thousands of these filings are received annually for all types of insurance (with the exception of reinsurance, and wet marine and transportation insurance for which filings are not required). The division has five people to review the property/casualty form filings and one person to review life and accident and health insurance filings. (See AS 21.42 and specifically AS 21.42.120-130.)

Rates are required to be filed before use for all types of property/casualty insurance except for reinsurance, disability, insurance on vessels, and insurance on aircraft. The same five staff identified above also perform the rate review process. Insurers must file and have approved before using rates for all types of property/casualty insurance except for reinsurance, disability, insurance on vessels, and aircraft insurance. Generally rates must be based on all relevant factors including past loss experience, margin for expenses, profit, catastrophe margins, dividends, and judgment. Statutory approval standards are that rates must not be excessive, inadequate, or unfairly discriminatory. Currently, we receive under 100 rate filings per year. However, this number will be increased due to the mode of filing to be undertaken by the Insurance Service Office (ISO), a rating organization. Beginning January 1, 1990, ISO will phase in filing only loss data rather than filing fully developed rates for its member and subscriber companies. This means that each member and subscriber insurer will need to file its own fully developed rates (which means that each must add in its own margins for expense, profit, dividend and contingency margins.) It has been estimated that the rate filings will increase to as many as 2,000 filings per year. (Attached are several months of filing activity reports which will provide a synopsis of this function.) Appeal processes are available at the administration hearing level before the director to any party impacted by a rate filing or by the application of a rating plan. The Division's authority is essentially limited to disapproval of a rate filing and assessing monetary penalties. The division does not have the authority to set rates. (See AS 21.39).

Market Conduct staff also performs on-sight examinations of insurers and agents and brokers. The purpose of this function is to ascertain if insurance transactions are being conducted in accordance with Alaska's insurance law and that approved forms and rates are being appropriately utilized. During the past 18 months two Market Conduct examinations have been performed of insurers and 10 of agents and brokers.

Licensing

This section licenses qualified individuals and insurance companies to market insurance in Alaska.

Generally, all persons desiring to transact the business of insurance in Alaska are required to be licensed by the division. These persons include agents, brokers, adjustors, and insurance companies. Persons desiring licensure as agent, brokers, and adjustors must meet certain statutory requirements and must successfully pass examinations that test knowledge of Alaska's insurance laws and specific insurance concepts.

Insurers must meet minimum statutory financial solvency standards and must have competent management in order to be licensed. Each insurer wishing to be licensed in Alaska must submit extensive documentation pertaining to its financial status which is reviewed by the division's two financial examiners.

An agent, broker, adjustor, or insurer is subject to sanctions for violation of Alaska's insurance law. After formal administrative hearing in which violations are found, penalties available are monetary penalties, suspension or revocation of the license, or a combination thereof.

Currently, Alaska has approximately 4,500 licensed agents, brokers, and adjustors, and 1100 licensed insurance companies (See AS 21.09 and AS 21.27).

Financial Surveillance

The primary responsibility of this section is to ensure solvency. Insolvent insurance companies cannot pay claims. One responsibility of the section is to examine insurance companies' financial records in order to verify that the company has sufficient reserves to protect policyholders, that investments meet statutory requirements and that reinsurance agreements comply with Alaska law. This section also is charged with performing financial examinations of producer licensees to verify trust accounts.

All Alaska based insurers are required to be financially examined at least once every three years by the division. Currently, there are 13 domestic insurers. Additionally, all foreign and alien insurers licensed in Alaska are required to be financially examined at least every three years. However, the law allows the division to accept examinations conducted by the foreign or alien insurer's state of domicile or state of entry respectively. (Reliance upon a state of domicile's examination is what is typically done not only by the division but other states rely upon the division's examination of Alaska's domiciled insurers as well.) However, annually all licensed insurers are required to file with the division extensive statements of their financial condition. These are reviewed by the division's two financial examiners to

help detect financially troubled companies and to determine the appropriate action. All Alaska domestic insurers as well as certain licensed foreign and alien insurers are required to file quarterly financial data. Currently, all financial examinations of Alaska Domiciled insurers is being done by contract with public accounting firms with division staff managing the examination. All Alaska domestic insurers have been examined or are in the course of being examined currently. The insurers directly bear the cost of examination.

Insurers found to be financially impaired are subject to summary suspension of their license. Additionally, for Alaska domestic insurers, the director is the statutory receiver under the direction of the state superior court for impaired or insolvent insurers. (This function is analogous to federal bankruptcy.) The director's role is similar to a bankruptcy trustee. The director actually takes full control of an impaired domestic insurer in order to rehabilitate it or serves as the liquidator for an insolvent insurer that is not rehabilitatable. In effect, the division gets into the business of running a financially troubled insurer. (See AS 21.78.)

The two division financial examiners also directly conduct examinations or manage contract auditors who conduct examinations of agent and brokers trust accounts. Agents and brokers are required to hold all premium funds in a fiduciary capacity and to account for those funds according to statutory requirements. In the last 18 months, the division financial examination staff have conducted personally three such examinations and have managed 12 contract examinations. Significant problems have been found, and in some instances, trust deficiencies alleged to be in excess of \$1,000,000 have been found. The expense of these examinations, by statute, is borne directly by the Division of Insurance. Again, administrative sanctions after a hearing can consist of monetary penalties, license suspension or revocation, or a combination thereof. Formal administrative proceedings have been initiated by the division in all instances where trust fund deficiencies have been alleged to exist. (See AS 21.27.350-360).

(Generally see AS 21.06.120-160, AS 21.09, AS 21.18, AS 21.21, AS 21.22, and AS 21.69).

Consumer Complaint and Investigation:

The function of this section is to investigate and resolve individual consumer complaints that are filed with the division. Statistical data that is collected by this section is utilized by the market conduct section as a means to identify licensees or trade practices that warrant further examination.

The division's consumer complaint staff consists of two consumer complaint specialists and an administrative assistant. This staff handles between 400 and 500 written complaints annually, most of which relate to health insurance and automobile insurance claims. The number of written complaints have been steadily increasing over the past several years. Additionally, this staff fields literally thousands of telephone calls from the general public seeking information about all types of insurance for every reason imaginable. The consumer complaint staff act as the "grass roots" source of detecting problems in the insurance market place. The division does not have the statutory authority to directly force the resolution of a consumer complaint by forcing an insurer, for example, to pay a claim at a certain dollar amount. However,

many times consumer remedies do come about through our involvement in a complaint. Primarily our complaint staff addresses alleged violations of AS 21.36 - Unfair Trade Practices and Frauds Act which includes the provisions pertaining to unfair claim settlement practices. Administrative sanctions available after hearing are again monetary penalties, license suspension or revocation, or a combination thereof.

2464

STATE OF ALASKA

DEPARTMENT OF ADMINISTRATION

DIVISION OF RISK MANAGEMENT

STEVE COWPER, GOVERNOR

P.O. BOX C
JUNEAU, ALASKA 99811-0218
PHONE: (907) 485-2180

January 17, 1989

Honorable John M. Andrews
Commissioner of Administration
State of Alaska
State Office Building
Juneau, AK 99811

Dear Commissioner Andrews:

I am pleased to present the FY 88 Annual Report for the Division of Risk Management.

Generally speaking the insurance markets were much improved over FY 87. They were willing to negotiate costs as well as improve coverages and policy conditions. Property, Marine and Aviation premiums have been substantially reduced while General Liability and Workers' Compensation renewed at approximately the same levels as last year. Specialty coverages such as directors and officers liability, medical malpractice, architects and engineers, errors and omissions and other high risk exposures continue to offer only limited markets. Pollution liability, asbestosis and discrimination insurance are almost impossible to find at practical premium costs for State exposures.

Risk Management is pleased to report transfer of 3.4 million dollars into the State Catastrophe Insurance Reserve account at the end of FY 88. This was the first deposit to the statutory catastrophe insurance fund which supports the State self-insured program and played an important roll in negotiating premium cost reductions for FY 89.

We take pride in delivery of timely claims services to injured employees and their dependents as well as fair and equitable adjudication of general and auto liability claims. Expediting repair or replacement of damaged State properties remains a priority item.

This annual report is meant to help readers understand the Risk Management process and its usefulness in controlling and reducing ultimate operating costs. We would be most happy to provide additional information or assistance on request.

Respectfully Submitted,



Donald J. Hitchcock
Director

DJH/ch

FUNCTIONS
OF THE
DIVISION OF RISK MANAGEMENT

Primary goal of the Division of Risk Management is to protect the State's assets from major loss through a combination of self-insured funding and excess insurance policies that are cost effective and provide adequate protection.

This objective is accomplished through four basic approaches to responsible Risk Management.

1. Administration and control of self-insurance and insured risk designed to be responsive to the individual needs of each State agency and in the best interests of the State as a whole.
2. Positive and aggressive control of claims brought against the State as well as claims for repair or replacement of damaged State properties. Fair and responsible settlement of claims in a timely and practical manner wherever possible. This function works in coordination with the Department of Law.
3. Provide State agencies with timely and accurate claims exhibits and analysis so that safety activities and accident prevention programs can be designed and implemented to create and maintain a safe place to work for our employees as well as protect the general public. These exhibits and services are for general use within the State system.
4. Responsible stewardship of the State Catastrophe Insurance Reserve Fund through planning to see that adequate funding is available as well as determination of proper claims payments (if any) to be made from the catastrophe fund.

INTRODUCTION TO RISK MANAGEMENT

Risk exists whenever the future is unknown. Since no one knows the future exactly, everyone is a risk manager, not by choice, but by sheer necessity.

The State of Alaska has physical, financial, and human resources that are coordinated to achieve present goals and establish new objectives. A substantial loss to any of these resources could cause financial loss, cancellation of programs and/or disruption of services or operations provided to the people of the State.

Risk management is the process of minimizing the adverse effects of loss through pre-planning and pre-funding of loss exposures. The Division of Risk Management acts much like an insurance company in paying injured Workers' Compensation claims, handling liability claims or lawsuits and providing funds for damage to State property ranging from the State Capitol Building to the Anchorage International Airport Complex and including such variations as the Marine Ferry System and Museum artifacts.

Risk Management is more than just purchasing insurance to pay losses. It involves the long-term commitment of the State to minimize the total cost of risk. Properly implemented, risk management avoids the unpleasant task of obtaining unbudgeted funds to finance restoration after a major loss.

During the past 20 years, risk management has become an essential part in the process of responsible corporate, municipal and state management. The State of Alaska has received the benefits of a risk management program since 1973 and State agencies have realized considerable savings and significantly increased protection over the years.

The State at one time was sheltered from liability suits by the doctrine of "Sovereign Immunity", however, legislative and court actions have substantially eroded that concept. Many court decisions apply the "deep pocket" theory in awarding damages to an injured party. This places the State in line for payment in many cases where the State has very questionable or no known liability. Workers' compensation statutory benefits in Alaska are the highest of all the states. Comparatively speaking, Alaska has more vested interest in high valued properties located in an environment considered hostile to normal fire fighting protection as well as other hazards such as temperature extremes, earthquakes and abnormally high winds. These major exposures have to be considered and controlled which should include provision for funding loss when necessary.

In basic terms, Risk Management strives to give less money to insurance companies and at the same time provide necessary protection and services (claims adjusting, etc.) through Alaska-based professional service contractors. Cost effective protection, safety awareness and claims management are the "keys" to a cost-effective and successful risk management program.

RISK MANAGEMENT SERVICES

RISK MANAGEMENT ADMINISTRATION

Responsibility for development of the State's total property and casualty insurance program; assessing additional insurance exposures or needs for new or special projects; providing evidence of insurance for all types of State activities; preparing annual insurance costs for State agencies; monitoring loss funds; overseeing annual actuarial and audit services and general administration of Risk Management's response to State needs are some of the services provided by the administrative section.

Marketing of the State's insurance program is done through contract brokers. Presently, our brokers are Corroon & Black and Bayly, Martin & Fay. The State's annual insurance actuarial reports are prepared by Coopers & Lybrand. Peat, Marwick, Main & Company provide audit services while computer services are provided by PCS of Anchorage. All Risk Management contract services are bid every three to five years.

Risk Management also provides services to the Alaska Power Authority and coordinates with or assists the University of Alaska and the Alaska Railroad when requested.

CLAIMS SERVICES

Claims Management provides services for investigation and/or adjustment of claims once an accident or occurrence is reported. The majority of workers' compensation and liability claims are handled through adjusting firms under contract. Most property claims are handled directly by Risk Management claims staff.

Northern Adjusters, Inc., with offices in Anchorage, Fairbanks, Juneau and other Alaska cities, handles automobile and general liability claims; EPIC Claims Services, Ketchikan, deals with claims on the Marine Highway System; Surety of Alaska, Anchorage, adjusts workers' compensation claims and also provides services for aviation and professional liability cases. Each firm is subject to periodic review by Risk Management claims officers, plus scheduled audits by independent claims professionals if necessary.

CONTRACT REVIEW

An important part of Risk Management's loss control services involves establishment or review of State contract insurance requirements. These are necessary to protect the State from claims caused by the acts of independent contractors.

Considering the present insurance market, State requirements have at times become difficult to obtain for many of the State's contractors. Risk Management is addressing this problem when necessary by revising contract requirements on an individual basis (or where applicable), on a specific program basis. During the past year, standard (boilerplate) insurance requirements for State contracts were again reviewed and modified where necessary and in the best interests of the State.

Due to the wide variety of State contracts, it is very difficult to adopt one program or even a series of programs to fit the needs of all contractual agreements. Boilerplate insurance requirements are considered guides and Risk Management will work with State agencies to consider revisions when requested.

Risk Management recommends that agencies remain involved and assist in contract insurance negotiations since they can better attest to the type of work involved, inherent exposures, possible statutory requirements and the importance of the specific contract to other possible areas of involvement.

LOSS CONTROL AND CLAIMS INFORMATION SERVICES

The starting point of any effective loss control program is to identify an agency's loss exposures. Loss exposures include the items or persons subject to a loss, the forces that may cause a loss, and the financial impact of the loss.

To assist agencies in determining where losses occur, how they occur and the costs incurred, Risk Management provides loss control reports (see page 5) to Administrative Directors, management level personnel and designated safety officers throughout the State.

Special reports may also be generated from Risk Management's claims database to provide specific listings of claims to cover a variety of needs. As an example, each vessel in the Marine Highway System and each State Pioneers' Home may receive a separate listing of claims incurred. Risk Management has also provided claims reports by specific type when requested, i.e., all open Workers' Compensation claims for specific fiscal years or all claims over \$25,000. which involved motor vehicles. Risk Management's claims analysis capabilities are extensive and available on request.

The effectiveness of any loss control or safety program is dependent on management support. "Safety" starts at the "top" because management support is absolutely necessary to its ultimate success.

Especially considering the high levels of self-insurance carried by the State of Alaska, "accident prevention" reduces costs, but just as importantly, a safe workplace improves productivity and boosts morale.

Division of Occupational Licensing
FY 89
Performance Report

The division is charged with the responsibility of providing administrative and budgetary support to 30 licensing programs, consisting of 19 professional boards, 2 commissions, 8 trades, business licenses.

One of the major challenges the division faced came at the start of FY 89 when the Business Licensing program was transferred from the Department of Revenue to the Department of Commerce and Economic Development, Division of Occupational Licensing. The transfer moved the regulatory and licensing responsibilities of more than 60,000 businesses which renewed annually; and a staff of less than half the number which supported the program on a continuing basis.

After placing the program within the division, the next major hurdle was to prepare for the license renewal period. Because all licenses carried an annual expiration date of December 31, license renewal forms were designed and mailed in November; and the renewal process began, less than six months from obtaining the program from the Department of Revenue. With relatively new employees that transferred with the program, division responsibilities to other licensing occupations were set aside for a few weeks to dedicate all division staff resources to complete the business license renewal process.

To alleviate the tremendous workload involved in annual business license renewals, the division placed all business licenses on a biennial renewal cycle and alphabetically separated the businesses, thereby reducing the renewal process to one half the number of licensees which must renew each year.

Businesses beginning with the letters A-J were renewed for a period of two years; while businesses beginning with the letters K-Z were renewed for one year. As of the December 31, 1989 license expiration date, all licensees will be placed on a biennial renewal cycle.

Another major project undertaken was to produce new maps of each game management unit to properly identify the big game hunting boundaries for each licensed guide. These areas were known as "exclusive guide areas". No sooner did the project get under way when a Supreme Court decision determined the "exclusive guide areas" to be unconstitutional. The ruling had a tremendous impact on the way big game guides were licensed. As a result, the newly created Guiding and Game Task Force was able to address this issue. New legislation was drafted which subsequently became law. The new bill reorganized the Guide Board and its licensing procedures. Operating under new legislation, the board is now known as the Big Game Commercial Services Board, and its license authority was expanded to include the licensing of outfitters, transporters, and all commercial users of the big game resource.

Sunset Reviews were conducted on four boards: Board of Barbers and Hairdressers, Board of Pharmacy, Board of Physical Therapy and Occupational Therapy Examiners, and the Board of Veterinary Examiners. All four boards were extended by the Legislature to 1993.

New licensing boards were created to regulate the professions of Clinical Social Workers, and Mechanical Administrators.

The licensing of Clinical Social Workers was created to ensure that social workers practicing psychotherapy who practice without supervision are competent and qualified.

The Board of Mechanical Examiners was created to regulate the mechanical aspects of the construction trade. The board's responsibilities include establishing new categories within the mechanical trade. A new category of licensure was also created under the Construction Contractor statutes for a Mechanical Contractor.

The division also participated in hosting two conferences in Alaska. The Pain Management Conference, held in Anchorage, was successful with a large number of participants from several health care professions in attendance. The conference included reputable guest speakers from out-of-state as well as board members, associations and interested public in general.

The second conference held was the Western Zone Meeting of the National Council of Engineering Examiners which was held in Fairbanks. Much of the coordination for the conference was accomplished by division staff and board members. This too, was a success!

The division also participated in the Prescription Abuse Data Synthesis (PADS) program and became the lead state agency involved with the program. PADS was originally developed by the American Medical Association in 1983, and for almost a year, more than a dozen Alaskan health care organizations have been working to reduce the abuse and diversion of prescription drugs. Diversion was defined as, the process by which drugs intended for legitimate medical use, become abused for illicit purposes. The PADS project involved four working groups: Technical, Regulatory/Enforcement, Professional Associations, and Policy; with each group focusing on various aspects of drug diversion.

For the first time the division issued warning and deactivation notices to construction contractors who failed to meet the bonding and/or insurance requirements. After finally obtaining additional staff help needed in the past to properly monitor compliance with bonding and insurance requirements of the many licensed contractors, the added scrutiny has gone a long way in encouraging compliance with the contractor licensing statutes.

The passage of federal legislation, known as the Nursing Home Reform Act, placed a federal mandate on each State to certify to the competency of all nurse aides working in long term health care (LTC) facilities. Nurse aides working at LTC facilities must be on the state's Nurse Aide Registry in order for the facility to remain eligible for medicare/medicaid funding. In cooperation with the Division of Medical Assistance (Department of Health & Social Services), the division assumed responsibility for administration of the state's Nurse Aide competency and certification program. A new position was created to coordinate development of the program; and progress is being made to meet the requirements imposed by the federal law.

Mandatory continuing education requirements were imposed for the first time during the license renewal period for medical doctors, and registered and practical nurses. Although the continuing education requirements already existed in statutes and regulations, they were applicable for the first time during the FY 89 renewals.

In FY 89, approximately 2,836 new licenses were issued, an increase from 2,569 issued in FY 88. Current licensees totalled approximately 25,140 as of June 30, 1989. In addition, 42,940 business licenses were issued as of January 1, 1989.

CONTACT PERSON

Randall P. Burns, Director
Division of Occupational Licensing
P.O. Box D-LIC
Juneau, AK 99811
(907) 465-2534

SCOMM

69:B9

#9

CLAIMS INFORMATION PROFESSIONAL

- 1) Liability Survey
- 2) Letter: 11/28/1989 From: Mary Pierce
- 3) Letter: 11/17/1989 to: Sam Cotten From: Janet Sloan Johnson
- 4) NICA Financial Database Sortfile

Claims Evaluations 3/28/1988

- 1) Evaluation Criteria and Report Format
- 2) Summary
- 3) Resume of Joyce Wainscott
- 4) Comments on Computer Database/Coding Addendum 1
- 5) Addendum 2
- 6) Addendum 3
- 7) Letter: 08/31/1989 To: Mary Pierce From: Jetta Whittaker
- 8) Letter: To: Jetta Whittaker From: Mary Pierce
- 9) Medical Indemnity Corporation of Alaska Reports and Studies
- 10) Letter: 04/19/1989 To: Mary Pierce From: Mary VandeCastle
- 11) Letter: 05/03/1989 To: MaryAnn VandeCastle From: Art Stanford
- 12) Letter: 04/27/1989 To: MaryAnn VandeCastle From: Janet Sloan Johnston
- 13) Letter: 11/21/1989 To: Mary Pierce From: Penne Chmielewski
- 14) Letter: 11/03/1989 To: Sam Cotten From: Douglas Smith
- 15) Liability Survey
- 16) Letter: 11/22/1989 To: David Rogers From: Ron Neupauer
- 17) Listing of Alaska Claims
- 18) Letter: 10/02/1989 To: Douglas Smith From: Ron Neupauer

- 19) Letter: 11/20/1989 To: David Rogers From: Patrick Hughes
- 20) Letter: 01/08/1989 To: David Rogers From: F. C. Ives
- 21) Alaska Professional Liability Loss and Premiums
- 22) Closed Professional Liability Claims for Alaska
- 23) Letter: 11/03/1989 To: David Rogers From: Bonnie Henkel
- 24) State of Alaska - Liability Survey
- 25) Letter: 11/02/1989 To: David Rogers From: Gary Bonham
- 26) Letter: 01/08/1990 To: Sam Cotten From: Thomas Porterfield, Jr.
- 27) Letter: 01/23/1986 From: Larry Laughman

American Institute of Architects

- 1) Survey
- 2) Letter: 07/29/1985 From: Larry Laughman
- 3) Questionnaire
- 4) Letter: 05/08/1985 To: Alaska Professional Design Council
From: Bernard Engals
- 5) Letter: 11/13/1989 To: David Rogers From: Lawrence Monin

Claims Information - Self Insured

- 1) Letter: 11/07/1989 To: David Rogers From: Brad Thompson
- 2) Letter: 12/28/1989 To: David Rogers From: Brad Thompson
- 3) Claims Made Analysis
- 4) Division of Risk Management
- 5) Letter: 10/30/1989 To: David Rogers From: Harry Sjoberg
- 6) Loss Experience Comparison
- 7) Letter: 10/30/1989 To: David Rogers From: H. P. Cutter
- 8) Letter: 11/01/1989 To: H. P. Cutter From: David Rogers

- 9) Letter: 11/17/1989 To: David Rogers From: Brian Rogers
- 10) Risk Management
- 11) State of Alaska Liability Survey
- 12) Letter: 11/17/1989 To: David Rogers From: Tom Bibeau
- 13) Liability Survey
- 14) Loss Summary
- 15) Letter: 11/28/1989 To: David Rogers From: Edward Zeine
- 16) Letter: 04/04/1989 From: Mr. Stanford
- 17) Resolution 89-24
- 18) Letter: 11/17/1989 To: David Rogers From: Gary Gandy
- 19) Ordinance #595
- 20) Letter: 11/19/1986 To: Judith Stevens From: Gary Gandy
- 21) MICA Meeting 01/15/1987

67.121

**CLAIMS INFORMATION
PROFESSIONALS**

STATE OF ALASKA

LIABILITY SURVEY

1. For each group, the total amount of premiums you have collected in Alaska for the last fifteen years which relate to liability insurance policies.
2. Claims information for the fifteen year period as follows:

Claim Synopsis

1. Date of event
2. Date suit filed
3. Date case settled/verdict received
4. Statute of limitations (exception/basis)
5. Percentage of comparative negligence
6. Total payment
7. Payment by each co-defendant
8. Collateral source (amount/source available)
9. Collateral source (amount/source allowed)
10. Case evaluation (if 100% liable)

Damages

1. Medical specials
2. Economic specials/income
3. Economic specials/out-going
4. Pain and suffering
5. Disfigurement
6. Loss of enjoyment of life
7. Punitive
8. Loss of consortium
9. Other (specify)
10. Prejudgment interest
11. Postjudgment interest

Method of Payment

1. Periodic payment (specifics)
2. Annuity (specifics)
3. Lump sum

Attorney Fees/Costs

1. Contingency fee/percentage plaintiff
2. Rule 82
3. Costs/plaintiff
4. Defense costs
5. Defense fees

3. From your experience, do you agree with this statement: "a small percentage of professionals in each group are responsible for a large percentage of the claims?" Do you have statistics to support your answer?

State of Alaska
Liability Survey
Page Two

4. If you carry other lines of liability insurance, please answer the above questions for each of those groups.
5. What is your current rate structure?
6. Are you aware of any availability problem in connection with any lines of liability insurance you carry?

MICA Medical Indemnity
Corporation of Alaska

ALEUT PLAZA
4000 OLD SEWARD HWY., SUITE 203
ANCHORAGE, ALASKA 99503
(907) 568-3414

November 28, 1989

Mr. David Rogers
Box 33932
Juneau, Alaska 99803

RE: Legislative Liability Task Force

Dear David:

I have enclosed several items as requested by the Legislative Liability Task Force.

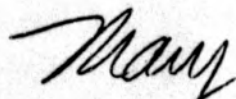
1. We have answered questions posed about our claims experience. I have also enclosed responses to two administrative requests regarding similar type questions which may prove helpful.
2. You also asked a question about agreeing with the statement that there are a few providers that generate most of the claims. I can't disagree with that statement since it is the basis of all insurance. What seems to be a between-the-lines question is that the few are the same few year after year. I have therefore included some information on our underwriting practices and how we cull out the "same few."
3. I have also included a summary of all the risk management activities that MICA has and continues to sponsor. I often hear the statement that healthcare providers are doing little to manage quality care. This list of activities should totally discount that statement.

Medical Indemnity Corporation of Alaska

Mr. David Rogers
November 28, 1989
Page 2

David, if you have any questions, please call me or if we can provide other information, please let me know.

Warm Regards,



Mary Pierce
Executive Director

MP/act

cc: Ray Schalow, ASMA
Harlan Knudson, HAA

MICA Medical Indemnity
Corporation of Alaska

ALEUT PLAZA
4000 OLD SEWARD HWY., SUITE 208
ANCHORAGE, ALASKA 99508
(907) 563-3414

November 17, 1989

Representative Sam Cotten
Chairman, House Liability Task Force
Alaska State Legislature
House of Representatives
P.O. Box V, State Capital
Juneau, Alaska 99811

RE: Informational Request of October 20, 1989

Dear Representative Cotten:

In attempting to promptly provide the information requested in your letter of October 20th, it seemed easiest to supply you with a claims audit completed at MICA in March of 1988 by Joyce Wainscott. I trust that you have seen this before. The study was completed at MICA's request by Ms. Wainscott whose CV is also attached.

Ms. Wainscott's study was more limited in scope than the information you are presently requesting. Specifically her study focused upon:

1. Only closed claims.
2. Only closed claims on which indemnity payment had been made.
3. Only closed claims where the indemnity payment had exceeded \$100,000.

Our computer data base, virtually non-existent when Ms. Wainscott began her study, has now progressed to the point that I can give you significantly expanded information, at least in some areas.

Representative Sam Cotten

November 17, 1989

Page 2

I'm attaching a computer run that references all of MICA's closed claims from the date of inception up to and including September 30th of 1989. I have included all closed claims whether or not indemnity was paid. Further, I have included files that are still pending (open) but on which we have already paid the indemnity portion. (We do not close a file until all financial transactions are complete including final attorney bills and reinsurance reimbursement if appropriate. So these are files where the indemnity has been finalized but the expense section is in the finalization stages.)

Attachment A. will draw your attention to some of the coding in our data base so that you can better understand the report.

Attachment B. will help to succinctly contrast the percentage of claims and/or suits closed with and without indemnity payment together with total average cost per file. The total average cost per file is further broken down to average indemnity payment and average LAE paid. Finally, that attachment draws your attention to the amount of each dollar spent on defense of a case in comparison to the amount reaching the plaintiff and/or his or her attorney.

Finally, in attachment C. I have referenced the list of claims information items you are requesting and commented on each item briefly. In some instances the information you seek is obtainable from the computer run. In some instances our computerization has not progressed to the point where we can readily capture the piece of data you are requesting. In still other cases our particular claims operation is not set up to focus on these items in an isolated fashion. Ms. Wainscott made this point in her previous report and I will simply reiterate it as being unchanged at the present time.

Medical Indemnity Corporation of Alaska

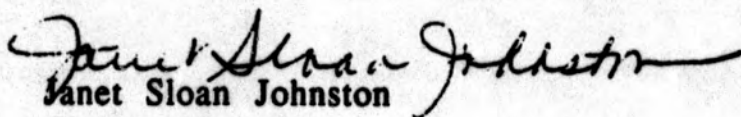
Representative Sam Cotten

November 17, 1989

Page 3

I hope the enclosed information will be of some assistance to you and to the Task Force. Please don't hesitate to contact me if I can be of further help.

Sincerely,


Janet Sloan Johnston
Claims Manager

Enclosure

JSJ/tmb

CURRENT AS OF SEPTEMBER 30, 1989

①

NICA
FINANCIAL DATABASE SORTFILE

N/H/R	FILE #	SEV.	FILE STATUS	D/O	D/R	DATE OF CLAIM	DATE CLOSED	DATE OF REOPENING	DATE OF FINAL CLOSURE	S.O.L.	***** TOTAL PAID ALL YEARS LOSS L&E	
											LOSS	L&E
N.D.	86-238-10	S	P	-84	-85						628,211.00	88,231.50
N.D.	86-314-86	S	P	-86	-86				(FINAL)		388,000.00	72,651.00
N.D.	86-232-040	S	P	-84	-86						178,992.17	185,252.31
N.D.	86-232-04C	S	P	-84	-86						178,992.16	183,492.30
N.D.	86-232-04A	S	P	-84	-86						88,621.09	24,877.97
N.D.	86-232-04A	S	P	-84	-86						88,621.00	24,868.60
											1,447,437.30	417,774.56
HOSP/NO	85-227-57	S	C	-83	-85	28-Dec-88					2,779,897.04	124,447.00
N.D.	85-283-330	S	C	-84	-85	30-Jun-88					2,200,000.00	13,846.84
N.D.	84-138-15	S	C	-81	-84	01-Feb-89					1,918,582.00	246,132.45
HOSP	84-137-22	S	C	-82	-84	13-Dec-88					1,798,500.00	395,253.01
HOSP	83-112-27	S	C	-82	-83	31-Mar-86					798,000.40	13,206.63
N.D.	83-091-86	S	C	-83	-83	30-Jun-85					558,000.10	32,664.85
N.D.	84-116-01	S	C	-82	-84	31-Mar-86					583,625.00	18,266.70
N.D.	85-197-27A	S	C	-84	-85	11-Jun-87					408,000.00	24,179.10
N.D.	83-098-13	S	C	-83	-83	31-Dec-84					333,665.96	25,379.04
N.D.	86-239-11A	S	C	-85	-86	17-Apr-89					388,000.00	9,186.13
N.D.	82-081-21	S	C	-81	-82	31-Mar-85					229,964.55	11,395.75
HOSP	88-041-18	S	C	-78	-88	28-Sep-83					228,000.00	85,267.91
HOSP	77-012	S	C	-77	-77	30-Jun-81					288,000.00	11,288.47
N.D.	84-132-17	S	C	-82	-84	15-Oct-87					196,000.00	36,359.00
N.D.	85-214-44	S	C	-85	-85	30-Sep-87					175,000.00	18,878.33
N.D.	84-121-06	S	C	-83	-84	31-Dec-86					170,000.00	14,982.86
N.D.	85-195-25	S	C	-83	-85	11-Jun-87					163,500.00	39,417.12
N.D.	77-010	S	C	-77	-77	30-Jun-79					158,000.00	11,453.56
HOSP	82-065-85	S	C	-82	-82	28-May-87					158,000.00	24,913.87
N.D.	82-067-87	S	C	-82	-82	28-May-87					158,000.00	21,933.11
N.D.	81-049-08	S	C	-79	-81	31-Mar-82					142,500.00	35,688.60
N.D.	86-238-02B	S	C	-85	-86	11-Jun-87					188,000.00	11,824.43
N.D.	86-238-02A	S	C	-85	-86	11-Jun-87					188,000.00	18,885.97
N.D.	84-178-55	S	C	-82	-84	04-Oct-88					99,628.10	31,906.10
N.D.	83-106-21	S	C	-81	-83	01-Aug-85					99,335.00	73,124.87
HOSP	83-089-04	S	C	-82	-83	30-Sep-85					98,000.00	44,208.72
N.D.	82-071-11	S	C	-80	-82	30-Jun-84					88,000.00	9,948.83
N.D.	82-073-13	S	C	-80	-82	30-Sep-84					88,000.00	4,948.58
HOSP	82-085-25	S	C	-82	-82	31-Dec-84					88,000.00	13,385.33
N.D.	85-281-31A	S	C	-83	-85	16-Dec-88					75,000.00	53,925.34
N.D.	88-028-85	S	C	-79	-88	30-Jun-87					75,000.00	4,856.74
N.D.	84-134-19	S	C	-82	-84	31-Mar-87					75,000.00	58,321.14
N.D.	84-138-23	S	C	-84	-84	31-Aug-87					58,000.00	37,478.68
N.D.	78-089	S	C	-76	-78	30-Jun-81					55,000.00	12,576.17
N.D.	82-069-09	S	C	-81	-82	31-Dec-84					58,285.44	15,234.64
HOSP	82-078-10	S	C	-81	-82	31-Dec-84					58,285.44	15,227.23

CURRENT AS OF SEPTEMBER 30, 1969

NICA

FINANCIAL DATA SOURCE SORTFILE

N/M/R	FILE #	SEV.	FILE	STATUS	D/O	D/R	DATE OF CLAIM	DATE OF CLOSING	DATE OF FINCL.	CLOSING	S.O.L.	LOSS	ALL YEARS	TOTAL PAID
-------	--------	------	------	--------	-----	-----	---------------	-----------------	----------------	---------	--------	------	-----------	------------

N.D.	67-132-22	5	C	-63	-77	-65	29-Dec-68	30-Jan-61	30,000.00	37,045.18		30,000.00	37,045.18
N.D.	78-014	5	C	-77	-77	-77	30-Jan-61	30-Jan-61	30,000.00	774.07		30,000.00	774.07
N.D.	65-191-21	5	C	-63	-63	-63	29-Oct-68	30-Sep-65	30,000.00	28,476.62		30,000.00	28,476.62
N.D.	67-437-27	5	C	-62	-62	-62	30-Oct-68	30-Oct-68	49,357.50	2,439.60		49,357.50	2,439.60
N.D.	67-465-75	5	C	-65	-65	-65	30-Oct-68	30-Jan-66	49,357.50	2,177.09		49,357.50	2,177.09
N.D.	62-004-24	5	C	-62	-62	-62	30-Jan-66	23-Apr-69	46,585.45	25,307.02		46,585.45	25,307.02
N.D.	63-222-32	5	C	-65	-65	-65	23-Apr-69	30-Sep-61	45,000.00	8,016.75		45,000.00	8,016.75
N.D.	79-021-07	5	C	-79	-79	-79	30-Sep-61	01-Aug-65	45,000.00	18,666.16		45,000.00	18,666.16
N.D.	60-027-04	5	C	-78	-78	-78	01-Aug-65	15-Oct-67	43,750.30	19,234.27		43,750.30	19,234.27
N.D.	64-131-16	5	C	-62	-62	-62	15-Oct-67	07-Aug-65	32,000.00	19,506.09		32,000.00	19,506.09
N.D.	64-122-07	5	C	-63	-64	-64	31-Dec-66	31-Dec-66	30,000.00	3,695.53		30,000.00	3,695.53
N.D.	64-141-25	5	C	-64	-64	-64	31-Aug-67	31-Aug-67	25,200.00	7,506.66		25,200.00	7,506.66
N.D.	76-003	5	C	-76	-76	-76	31-Mar-78	16-Dec-68	25,000.00	697.68		25,000.00	697.68
N.D.	65-190-28	5	C	-63	-63	-63	31-Mar-67	30-Jun-63	25,000.00	15,576.93		25,000.00	15,576.93
N.D.	61-052-11	5	C	-61	-61	-61	30-Jun-63	26-Feb-66	25,000.00	83,249.00		25,000.00	83,249.00
N.D.	67-482-72	5	C	-65	-65	-65	26-Feb-66	30-Jun-63	28,100.16	33,727.75		28,100.16	33,727.75
N.D.	61-046-05	5	C	-79	-61	-61	30-Jun-63	30-Jun-63	28,000.00	3,739.14		28,000.00	3,739.14
N.D.	65-210-40	5	C	-64	-64	-64	15-Mar-68	30-Sep-65	28,000.00	21,642.72		28,000.00	21,642.72
N.D.	62-075-19	5	C	-62	-62	-62	30-Sep-65	31-Mar-67	12,500.00	18,501.47		12,500.00	18,501.47
N.D.	66-234-06	5	C	-63	-66	-66	31-Mar-67	31-Mar-67	12,500.00	74,674.00		12,500.00	74,674.00
N.D.	64-117-02	5	C	-62	-62	-62	31-Mar-67	31-Mar-61	10,000.00	11,720.45		10,000.00	11,720.45
N.D.	62-076-16	5	C	-61	-61	-61	31-Mar-66	31-Mar-66	7,750.00	3,542.03		7,750.00	3,542.03
N.D.	63-094-09	5	C	-61	-61	-61	31-Dec-64	30-Jan-66	7,000.00	8,839.06		7,000.00	8,839.06
N.D.	63-103-20	5	C	-61	-61	-61	30-Jan-66	31-Mar-66	6,500.00	38,067.33		6,500.00	38,067.33
N.D.	63-099-14	5	C	-61	-61	-61	31-Dec-64	31-Dec-64	3,750.00	2,322.25		3,750.00	2,322.25
N.D.	64-154-39	5	C	-64	-64	-64	15-Sep-69	30-Sep-69	3,000.00	7,446.21		3,000.00	7,446.21
N.D.	60-026-03	5	C	-79	-79	-79	30-Jun-61	30-Jun-61	2,000.00	9,920.57		2,000.00	9,920.57
N.D.	62-061-01	5	C	-60	-60	-60	31-Mar-65	22-Jul-67	0.00	11,939.07		0.00	11,939.07
N.D.	65-216-468	5	C	-63	-65	-65	22-Jul-67	30-Sep-68	0.00	1,245.33		0.00	1,245.33
N.D.	78-010	5	C	-76	-78	-78	30-Sep-68	31-Mar-66	0.00	5,070.62		0.00	5,070.62
N.D.	64-145-300	5	C	-61	-64	-64	31-Mar-66	24-Mar-68	0.00	17,671.85		0.00	17,671.85
N.D.	65-237-09	5	C	-66	-66	-66	24-Mar-68	29-Jul-66	0.00	0.00		0.00	0.00
N.D.	65-220-500	5	C	-63	-65	-65	29-Jul-66	09-Jun-67	0.00	0.00		0.00	0.00
N.D.	67-491-01	5	C	-66	-67	-67	09-Jun-67	31-Mar-65	0.00	3,845.54		0.00	3,845.54
N.D.	61-043-02	5	C	-61	-61	-61	31-Mar-65	30-Jun-62	0.00	4,169.99		0.00	4,169.99
N.D.	60-038-15	5	C	-60	-60	-60	30-Jun-62	31-Dec-64	0.00	4,340.40		0.00	4,340.40
N.D.	62-066-06	5	C	-61	-62	-62	31-Dec-64	19-Dec-68	0.00	144,557.08		0.00	144,557.08
N.D.	64-129-14	5	C	-61	-64	-64	19-Dec-68	11-Oct-67	0.00	613.57		0.00	613.57

15,439,608.02 2,312,937.92

13X

2

CURRENT AS OF SEPTEMBER 30, 1989

NICA

FINANCIAL DATABASE SORTFILE

N/N/R	FILE #	SEV.	FILE	D/O	D/R	CLAIM	DATE OF	CLOSED	DATE OF	REOPENING	CLOSURE	S.O.L.	LOSS	TOTAL PAID	ALL YEARS	LSE
-------	--------	------	------	-----	-----	-------	---------	--------	---------	-----------	---------	--------	------	------------	-----------	-----

N.D.	HOSP	84-145-38E	S	C		81	81	81	11-Oct-87				0.00	0.00	0.00	0.00
N.D.	HOSP	82-082-22	S	C		80	82	82	30-Sep-84				0.00	0.00	0.00	0.00
N.D.	HOSP	85-216-16C	S	C		83	83	83	22-Jul-87				0.00	0.00	0.00	0.00
N.D.	HOSP	88-032-09	S	C		77	77	80	30-Jun-83				0.00	0.00	0.00	0.00
N.D.	HOSP	85-294-34A	S	C		83	83	85	31-Dec-87				0.00	0.00	0.00	0.00
N.D.	HOSP	86-232-24A	S	C		79	79	86	23-Dec-88				0.00	0.00	0.00	0.00
N.D.	HOSP	79-029-06	S	C		77	77	79	30-Sep-82				0.00	0.00	0.00	0.00
N.D.	HOSP	85-213-43	S	C		84	84	85	28-Apr-89				0.00	0.00	0.00	0.00
N.D.	HOSP	84-140-25	S	C		82	82	84	30-Jun-85				0.00	0.00	0.00	0.00
N.D.	HOSP	83-181-11	S	C		84	84	85	30-Jun-86				0.00	0.00	0.00	0.00
N.D.	HOSP	84-145-38C	S	C		81	81	84	11-Oct-87				0.00	0.00	0.00	0.00
N.D.	HOSP	86-328-100	S	C		86	86	86	10-Feb-89				0.00	0.00	0.00	0.00
N.D.	HOSP	85-284-34B	S	C		83	83	85	83-Dec-87				0.00	0.00	0.00	0.00
N.D.	HOSP	82-068-08	S	C		82	82	82	30-Jun-84				0.00	0.00	0.00	0.00
N.D.	HOSP	85-999-063	S	C		85	85	85	15-May-89				0.00	0.00	0.00	0.00
N.D.	HOSP	88-031-08	S	C		79	79	80	30-Sep-81				0.00	0.00	0.00	0.00
N.D.	HOSP	82-072-12	S	C		80	82	82	30-Jun-84				0.00	0.00	0.00	0.00
N.D.	HOSP	81-045-04	S	C		78	81	81	30-Jun-82				0.00	0.00	0.00	0.00
N.D.	HOSP	76-001	S	C		76	77	77	30-Sep-83				0.00	0.00	0.00	0.00
N.D.	HOSP	82-078-18	S	C		81	82	82	31-May-86				0.00	0.00	0.00	0.00
N.D.	HOSP	85-284-34C	S	C		83	83	85	83-Dec-87				0.00	0.00	0.00	0.00
N.D.	HOSP	78-002	S	C		78	77	78	30-Jun-83				0.00	0.00	0.00	0.00
N.D.	HOSP	86-289-61	S	C		85	86	86	83-Jul-86				0.00	0.00	0.00	0.00
N.D.	HOSP	85-281-31B	S	C		83	83	85	30-Oct-88				0.00	0.00	0.00	0.00
N.D.	HOSP	77-000	S	C		77	77	77	30-Jun-82				0.00	0.00	0.00	0.00
N.D.	HOSP	83-092-07	S	C		82	82	83	30-Sep-84				0.00	0.00	0.00	0.00
N.D.	HOSP	78-005	S	C		78	77	78	31-May-79				0.00	0.00	0.00	0.00
N.D.	HOSP	86-233-05B	S	C		84	86	86	30-Jun-86				0.00	0.00	0.00	0.00
N.D.	HOSP	88-037-14	S	C		80	80	80	30-Jun-82				0.00	0.00	0.00	0.00
N.D.	HOSP	83-100-15	S	C		83	83	83	30-Jun-85				0.00	0.00	0.00	0.00
N.D.	HOSP	85-216-46A	S	C		83	85	85	22-Jul-87				0.00	0.00	0.00	0.00
N.D.	HOSP	85-281-31D	S	C		83	85	85	30-Jun-88				0.00	0.00	0.00	0.00
N.D.	HOSP	77-011	S	C		77	77	77	31-May-78				0.00	0.00	0.00	0.00
N.D.	HOSP	81-060-19	S	C		81	81	81	30-Sep-84				0.00	0.00	0.00	0.00
N.D.	HOSP	83-107-22	S	C		81	81	83	31-Dec-84				0.00	0.00	0.00	0.00
N.D.	HOSP	87-438-28	S	C		86	86	87	19-Dec-88				0.00	0.00	0.00	0.00
N.D.	HOSP	88-036-13	S	C		79	80	80	31-May-85				0.00	0.00	0.00	0.00
N.D.	HOSP	87-536-146	S	C		86	87	87	30-Nov-87				0.00	0.00	0.00	0.00
N.D.	HOSP	87-469-59	S	C		81	87	87	12-Aug-88				0.00	0.00	0.00	0.00
N.D.	HOSP	86-360-132	S	C		86	86	86	15-Sep-89				0.00	0.00	0.00	0.00
N.D.	HOSP	84-120-05	S	C		84	84	84	31-Dec-84				0.00	0.00	0.00	0.00
N.D.	HOSP	86-233-05A	S	C		84	86	86	30-Jun-86				0.00	0.00	0.00	0.00
N.D.	HOSP	84-150-43	S	C		82	84	84	31-May-86				0.00	0.00	0.00	0.00
N.D.	HOSP	87-537-147	S	C		87	87	87	30-Jun-88				0.00	0.00	0.00	0.00
N.D.	HOSP	84-145-38D	S	C		81	84	84	11-Oct-87				0.00	0.00	0.00	0.00
N.D.	HOSP	86-229-01	S	C		85	86	86	31-Jul-88				0.00	0.00	0.00	0.00
N.D.	HOSP	87-567-157	S	C		85	87	87	27-Jun-88				0.00	0.00	0.00	0.00

3

CURRENT AS OF SEPTEMBER 30, 1969

NICA
FINANCIAL DATABASE SORTFILE

N/R	FILE #	FILE	STATUS	D/O	D/R	DATE OF CLAIM	DATE OF CLOSURE	DATE OF FINL	S.O.L.	TOTAL PAID	ALL YEARS	LOSS	LCB
-----	--------	------	--------	-----	-----	---------------	-----------------	--------------	--------	------------	-----------	------	-----

N.D.	65-178-00		S	C	63	65	31-Mar-67			2,336.75	0.00	2,336.75	0.00
N.D.	64-136-21		S	C	62	64	13-Dec-66			186,352.46	0.00	186,352.46	0.00
N.D.	64-144-29		S	C	61	64	31-Dec-65			3,997.75	0.00	3,997.75	0.00
N.D.	64-156-41		S	C	64	64	30-Jun-67			21,990.00	0.00	21,990.00	0.00
N.D.	65-162-128		S	C	64	65	03-Jun-68			552.75	0.00	552.75	0.00
N.D.	65-207-37		S	C	65	65	30-Jun-66			661.50	0.00	661.50	0.00
N.D.	62-677-17		S	C	61	62	31-Mar-66			2,417.61	0.00	2,417.61	0.00
N.D.	70-611		S	C	70	70	30-Sep-62			61,693.77	0.00	61,693.77	0.00
N.D.	64-153-30		S	C	63	64	31-Jan-68			0.00	0.00	0.00	0.00
N.D.	65-225-35		S	C	65	65	31-Dec-66			2,501.17	0.00	2,501.17	0.00
N.D.	63-693-08		S	C	62	63	30-Sep-64			9,681.00	0.00	9,681.00	0.00
N.D.	65-228-588		S	C	63	65	28-Jul-66			0.00	0.00	0.00	0.00
N.D.	63-101-16		S	C	62	63	00-May-65			4,079.46	0.00	4,079.46	0.00
N.D.	60-629-06		S	C	70	60	30-Sep-65			35,427.70	0.00	35,427.70	0.00
N.D.	64-164-49		S	C	62	65	02-May-68			32,330.30	0.00	32,330.30	0.00
N.D.	67-444-34		S	C	67	67	10-Feb-68			0.00	0.00	0.00	0.00
N.D.	61-647-06		S	C	79	61	30-Jun-63			6,219.16	0.00	6,219.16	0.00
N.D.	79-623-09		S	C	77	79	30-Sep-63			4,959.06	0.00	4,959.06	0.00
N.D.	79-617-03		S	C	70	70	30-Jun-62			14,777.26	0.00	14,777.26	0.00
N.D.	63-163-18		S	C	63	63	30-Jun-65			32,663.12	0.00	32,663.12	0.00
N.D.	79-619-65		S	C	77	79	30-Sep-62			2,292.37	0.00	2,292.37	0.00
N.D.	70-604		S	C	77	70	31-Mar-79			0.00	0.00	0.00	0.00
N.D.	67-557-147		S	C	67	67	30-Jun-68			0.00	0.00	0.00	0.00
N.D.	65-999-677		S	C	65	65	15-Apr-69			997.35	0.00	997.35	0.00
N.D.	66-252-24C		S	C	79	66	29-Dec-68			0.00	0.00	0.00	0.00
N.D.	68-610-31		S	C	65	68	29-Dec-68			3,218.69	0.00	3,218.69	0.00
N.D.	66-374-146		S	C	66	66	16-Dec-68			0.00	0.00	0.00	0.00
N.D.	76-604		S	C	76	76	14-Dec-77			0.00	0.00	0.00	0.00
N.D.	63-113-28		S	C	63	63	31-Dec-66			41,049.61	0.00	41,049.61	0.00
N.D.	63-695-10		S	C	61	63	30-May-67			4,448.91	0.00	4,448.91	0.00
N.D.	64-150-35		S	C	70	64	31-Mar-66			7,696.01	0.00	7,696.01	0.00
N.D.	62-662-02		S	C	60	62	30-Jun-62			1,686.28	0.00	1,686.28	0.00
N.D.	64-133-28		S	C	62	64	15-May-67			15,559.02	0.00	15,559.02	0.00
N.D.	65-162-129		S	C	64	65	03-Jun-68			6,544.74	0.00	6,544.74	0.00
N.D.	64-119-04		S	C	64	64	30-Sep-64			2,854.21	0.00	2,854.21	0.00
N.D.	66-252-24B		S	C	79	66	29-Dec-68			0.00	0.00	0.00	0.00
N.D.	68-668-61		S	C	66	68	09-Aug-69			0.00	0.00	0.00	0.00
N.D.	65-163-13		S	C	64	65	30-Jul-68			10,368.11	0.00	10,368.11	0.00
N.D.	63-696-05		S	C	62	63	31-Jul-67			55,774.94	0.00	55,774.94	0.00
N.F.	63-696-11		S	C	63	63	31-Dec-66			55,657.46	0.00	55,657.46	0.00

TOTAL CLOSED 5'S

15,439,688.02 3,376,988.68

0.00 1,064,058.76

10%

100%

4

CURRENT AS OF SEPTEMBER 30, 1989

NICA
FINANCIAL DATABASE SORTFILE

N/W/R	FILE #	FILE	STATUS	D/O	D/R	DATE OF CLAIM	DATE OF CLOSURE	DATE OF REOPENING	DATE OF FINAL CLOSURE	S.O.L.	LOSS	TOTAL PAID	ALL YEARS	LOC
-------	--------	------	--------	-----	-----	---------------	-----------------	-------------------	-----------------------	--------	------	------------	-----------	-----

HOSP	78-086					78	04-Oct-88	30-Sep-78	01-Sep-88		35,425.99	1,438.06	0.00	
N.D.	89-786-32					89	03-Jan-89				5,508.00	1,438.06	0.00	
N.D.	89-730-56A					89					2,438.00	0.00	0.00	
N.D.	89-730-56B					89					2,438.00	0.00	0.00	

N.D.	85-218-48					85	24-Dec-86				888,000.00	6,497.73	0.00	
N.D.	86-244-16					86	10-Jan-86				512,758.00	1,639.00	0.00	
N.D.	84-143-28					84	31-Mar-86				312,588.28	12,178.75	0.00	
N.D.	84-149-34					84	31-Dec-86				106,667.00	2,581.02	0.00	
HOSP	87-424-14					86	28-Oct-88				185,000.00	19,133.28	0.00	
N.D.	86-242-14A					86	16-Dec-88				112,588.00	17,565.19	0.00	
N.D.	83-111-26					83	30-Sep-84				112,588.00	11,756.99	0.00	
N.D.	85-190-28					85	31-Dec-85				108,000.00	2,387.18	0.00	
N.D.	87-075-15					82	30-Sep-82				108,000.00	3,935.75	0.00	
N.D.	88-025-02					88	30-Jan-81				58,000.00	3,438.30	0.00	
N.D.	88-999-096					88	18-Sep-89				48,083.81	4,758.55	0.00	
N.D.	85-106-16					85	31-Dec-85				45,000.00	1,436.64	0.00	
N.D.	88-035-12					88	30-Jun-81				45,000.00	2,064.85	0.00	
N.D.	85-108-10					85	30-Jan-86				35,000.00	0.00	0.00	
N.D.	83-008-03					82	30-Sep-83				25,000.00	2,273.75	0.00	
N.D.	85-223-53					85	31-Mar-86				28,000.00	0.00	0.00	
N.D.	84-166-51					84	31-Mar-85				28,000.00	0.00	0.00	
N.D.	87-544-134					87	02-Sep-88				15,300.00	2,688.38	0.00	
N.D.	86-251-23					85	30-Oct-87				10,000.00	3,788.16	0.00	
HOSP/WB	84-155-48					84	31-Mar-85				8,317.50	0.00	0.00	
HOSP	84-142-27					84	06-Feb-85				8,174.00	0.00	0.00	
N.D.	84-118-03					84	23-Aug-84				7,883.18	1,118.00	0.00	
N.D.	84-124-09					84	26-Nov-85				7,588.00	0.00	0.00	
N.D.	77-087					77	31-Dec-78				7,588.00	0.00	0.00	
N.D.	88-024-01					88	30-Sep-81				6,711.18	1,558.88	0.00	
N.D.	86-246-18					86	18-Oct-86				5,995.89	0.00	0.00	
N.D.	86-236-08					86	04-Dec-86				5,000.00	0.00	0.00	
N.D.	86-241-13					86	16-Sep-86				4,786.72	0.00	0.00	
N.D.	88-644-65					88	04-Nov-88				3,000.00	0.00	0.00	
N.D.	85-175-05					85	30-Jun-86				2,529.28	0.00	0.00	
N.D.	81-054-13					81	30-Sep-82				2,588.00	283.98	0.00	
HOSP	82-063-03					82	30-Jun-82				2,445.00	718.45	0.00	
N.D.	86-258-38					86	31-Mar-87				2,285.66	0.00	0.00	
N.D.	86-235-07					86	18-Dec-86				2,087.55	288.00	0.00	
R/F	83-118-25					83	31-Mar-84				2,088.00	578.00	0.00	
N.D.	87-416-86					87	09-Mar-87				1,843.78	0.00	0.00	
HOSP	83-087-02					83	31-Mar-83				1,888.00	486.39	0.00	
HOSP	85-187-17					84	31-Mar-86				848.24	26.45	0.00	
N.D.	85-211-41					84	30-Jun-86				831.88	0.00	0.00	

CURRENT AS OF SEPTEMBER 30, 1989

6

NICA
FINANCIAL DATABASE SORTFILE

N/W/R	FILE #	SEV.	FILE STATUS	D/O	D/R	DATE OF CLAIM	DATE CLOSED	DATE OF REOPENING	DATE OF FINAL CLOSURE	S.O.L.	***** TOTAL PPID ALL YEARS LOBS LAE	
											LOBS	LAE
N.D.	86-256-28	4	C	85	86		31-Mar-87				688.00	0.00
N.D.	86-254-25	4	C	86	86		31-Mar-87				476.38	100.00
HOSP	88-642-63	4	C	88	88		27-Sep-88				318.00	0.00
R/C	87-532-122	4	C	87	87		09-Sep-87				223.61	0.00
											2,828,410.70	103,993.41
N.D.	85-197-278	4	C	83	85		03-Jun-88				0.00	8,486.70
N.D.	88-591-12	4	C	84	88		19-Dec-88				0.00	0.00
N.D.	86-238-228	4	C	86	86		31-Mar-87				0.00	0.00
HOSP	88-839-16	4	C	88	88		31-Dec-81				0.00	1,765.30
N.D.	88-584-85	4	C	88	88		31-Mar-88				0.00	0.00
N.D.	87-425-158	4	C	86	87		30-Sep-87				0.00	0.00
HOSP	86-238-228	4	C	86	86		31-Mar-87				0.00	0.00
N.D.	85-224-548	4	C	85	85		16-Sep-87				0.00	0.78
N.D.	85-215-45	4	C	85	85		19-Dec-88				0.00	0.00
N.D.	87-574-164	4	C	87	87		19-Dec-88				0.00	0.00
N.D.	85-176-86	4	C	83	85		31-Dec-85				0.00	319.50
N.D.	87-571-161	4	C	87	87		11-Apr-88			15-Dec-89	0.00	0.00
HOSP	82-864-84	4	C	82	82		30-Jun-83				0.00	5,362.80
N.D.	85-172-82	4	C	84	85		30-Sep-85				0.00	1,158.50
N.D.	85-177-87	4	C	84	85		31-Dec-85				0.00	275.43
N.D.	83-184-19	4	C	82	83		31-Mar-84				0.00	547.56
R/C	81-858-17	4	C	77	81		31-Dec-82				0.00	885.50
N.D.	87-427-17	4	C	86	87		07-Aug-87				0.00	0.00
N.D.	81-853-12	4	C	80	81		30-Jun-82				0.00	0.00
HOSP	85-221-51	4	C	85	85		03-Dec-87				0.00	0.00
N.D.	85-226-568	4	C	85	85		00-Jun-87				0.00	0.00
HOSP	76-882	4	C	76	77		30-Sep-83				0.00	48,352.96
N.D.	85-179-89	4	C	83	85		10-Aug-87				0.00	1,162.00
N.D.	85-173-83	4	C	85	85		30-Jun-85				0.00	0.00
HOSP	83-189-24	4	C	83	83		31-Mar-84				0.00	1,300.62
N.D.	77-882	4	C	77	77		30-Jun-78				0.00	168.45
N.D.	78-883	4	C	77	77		31-Dec-78				0.00	62.50
HOSP/ND	85-999-869	4	C	85	85		16-Jan-88				0.00	857.50
N.D.	83-886-81	4	C	82	83		30-Jun-83				0.00	0.00
N.D.	85-212-42C	4	C	84	85		07-Nov-87				0.00	365.33
HOSP	88-834-11	4	C	88	88		31-Dec-82				0.00	443.65
HOSP	81-857-16	4	C	81	81		31-Mar-83				0.00	9,965.18
N.D.	83-897-12	4	C	82	83		31-Mar-87				0.00	21,654.47
N.D.	85-288-38	4	C	84	85		28-Aug-86				0.00	0.00
N.D.	86-255-27	4	C	86	86		00-Aug-88				0.00	10.00
N.D.	88-598-198	4	C	86	88		25-Aug-88				0.00	0.00
N.D.	88-595-16	4	C	87	88		22-Mar-88				0.00	0.00
N.D.	87-419-89	4	C	86	87		16-Jan-88				0.00	0.00
N.D.	85-226-56A	4	C	85	85		00-Jun-87				0.00	0.00
HOSP	88-598-19A	4	C	86	88		25-Aug-88			31-Jan-90	0.00	0.00

CURRENT AS OF SEPTEMBER 30, 1989

7

NICA
FINANCIAL DATABASE SORTFILE

N/W/R	FILE #	SEV.	FILE STATUS	D/O	D/R	DATE OF CLAIM	DATE CLOSED	DATE OF REOPENING	DATE OF FINAL CLOSURE	S.O.L.	***** TOTAL PAID *****	
											LOSS	ALL YEARS LAE
HOSP	88-848-17	4	C	79	88	30-Sep-81					0.00	485.00
N.D.	84-157-42	4	C	83	84	30-Jun-85					0.00	0.00
HOSP	81-844-83	4	C	81	81	31-Dec-81					0.00	976.25
N.D.	86-248-12	4	C	86	86	31-May-88					0.00	381.58
HOSP	87-425-158	4	C	86	87	30-Sep-87					0.00	0.00
HOSP	79-816-82	4	C	77	79	83-Apr-79					0.00	1,098.48
HOSP	85-224-54C	4	C	85	85	16-Sep-87					0.00	0.00
N.D.	81-858-89	4	C	78	81	30-Jun-82					0.00	784.34
HOSP	85-185-15	4	C	85	85	31-Dec-85					0.00	1,217.83
N.D.	79-818-84	4	C	78	79	30-Sep-79					0.00	0.00
N.D.	86-259-31	4	C	86	86	28-Oct-87					0.00	0.00
N.D.	85-174-84	4	C	82	85	30-Jun-85					0.00	0.00
RHC	87-489-79	4	C	87	87	19-Dec-88					0.00	2,183.85
N.D.	87-326-116	4	C	87	87	11-Apr-88					0.00	58.00
N.D.	87-435-25	4	C	82	87	24-Aug-87					0.00	1,743.38
N.D.	88-667-88	4	C	88	88						0.00	255.85
HOSP	78-813	4	C	78	78	31-Mar-79					0.00	379.86
N.D.	85-286-36	4	C	85	85	30-Jun-87					0.00	0.00
N.D.	81-855-14	4	C	81	81	30-Jun-82					0.00	1,163.58
HOSP	85-212-428	4	C	84	85	87-Nov-87					0.00	365.33
N.D.	85-224-548	4	C	85	85	16-Sep-87					0.00	0.00
N.D.	86-245-17	4	C	86	86	85-Jan-87					0.00	0.00
N.D.	85-212-428	4	C	84	85	87-Nov-87					0.00	686.33
HOSP	77-884	4	C	77	77	14-Dec-77					0.00	0.00
N.D.	88-688-21	4	C	87	88	19-Dec-88					0.00	0.00
HOSP	79-815-81	4	C	78	78	31-Mar-79					0.00	0.00
N.D.	82-888-28	4	C	82	82	31-Mar-83					0.00	1,814.58
N.D.	86-247-19	4	C	85	86	30-Oct-87					0.00	1,573.38
N.D.	84-151-36	4	C	84	84	31-Mar-85					0.00	1,488.28
N.D.	88-599-288	4	C	87	88	27-Jun-88					0.00	46.00
HOSP	87-572-162	4	C	85	87	12-Sep-88					0.00	268.00
N.D.	87-498-88	4	C	87	87	26-Oct-87					0.00	0.00
											0.00	119,778.49
TOTAL CLOSED 4'S											2,828,418.70	223,763.98
											19,753,339.21	4,819,965.28

100%

7%

17%

CLAIMS EVALUATION

JOYCE WAINSCOTT

MARCH 28, 1988

CLAIMS EVALUATION

A Study of Verdicts/Settlements

In January 1988 I began a review of a designated portion of the Medical Indemnity Corporation of Alaska (MICA) claims files. This review was initiated in response to a request for information regarding claims settlements and verdicts from the MICA Executive Board and the Alaska State Medical Association. The study was intended to gather information from the designated files and extrapolate potential verdicts/settlements under various tort reform statutes and proposals. The goal was to utilize that information to determine what impact, if any, present tort reform statutes would have on medical malpractice in the state of Alaska. I viewed my role in this project as that of recording information from specific files and projecting the effects of tort reform on damages paid.

EVALUATION CRITERIA AND REPORT FORMAT

To respond to the questions that were posed I determined that I needed to review the files for the following information:

1. Claims Synopsis
2. Damages
3. Attorney Fees and Costs
4. Method of Payment

Specific information in each of these categories would be further broken down as follows:

Claim Synopsis

1. Date of Event
2. Date Suit Filed
3. Date Case Settled/Verdict Received
4. Statute of Limitations (Exception/Basis)
5. Percentage of Comparative Negligence
6. Total Payment
7. Payment by Each Co-Defendant
8. Collateral Source (Amount/Source Available)
9. Collateral Source (Amount/Source Allowed)
10. Case Evaluation (If 100% Liable)

Damages

1. Medical Specials
2. Economic Specials/Income
3. Economic Specials/Out-Going
4. Pain and Suffering
5. Disfigurement
6. Loss of Enjoyment of Life
7. Punitive
8. Loss of Consortium
9. Other (Specify)
10. Prejudgment Interest
11. Postjudgment Interest

Method of Payment

1. Periodic Payment (Specifics)
2. Annuity (Specifics)
3. Lump Sum

Attorney Fees/Costs

1. Contingency Fee/Percentage Plaintiff
2. Rule 82
3. Costs/Plaintiff
4. Defense Costs
5. Defense Fees

My instructions were to evaluate only those files which were reflected as closed on December 31, 1987 and for which a payment of over \$100,000 had been reported.

The study encompassed twenty-eight (28) occurrences and forty-two (42) files with dates of event from August 6, 1976 to April 8, 1986.

Composition of Files

Of the forty-two reviewed, forty (40) were settled prior to trial, two (2) were tried. One case resulted in a defense verdict, the other in a plaintiff verdict. In terms of occurrences twenty-six (26) were settled with two (2) tried.

Ninety-five percent (95%) of the cases reviewed were settled prior to trial. Liability in those cases was determined in the following manner as regards primary liability. Final determination always included medical expert review and may have been a combination of two or more of the following:

Peer Review - 60%

Court Appointed Advisory Panel - 10%

Hospitals/Physicians Admission of Liability - 7.5%

MICA Claims Management* - 22.5%

* MICA Claims Management is defined as the Claims Manager, Claims Committee, Risk Management Committee and defense counsel for the insured.

EVALUATION

Rule 82

Four occurrences reflected payments of Rule 82.

1. \$15,000 payment to MICA as a result of a defense verdict. (13.6% of actual cost to defend).
2. \$40,000 paid by MICA in a plaintiff verdict. (This amount was 18.2% of an ultimate compromise settlement after the verdict. The court actually used its discretion in setting fees in this case and did not use Rule 82 guidelines).
3. \$13,500 paid by MICA in attorney fees as part of a compromise settlement (8.2% of the total settlement paid by MICA).
4. \$12,750 paid by MICA in a compromise settlement (2.4% of total settlement).

NOTE: (While exposure to Rule 82 was documented as being considered in determining settlement values, the above cases are the only payments in the files reviewed.)

Non-Economic Damages

Most of the cases were settled prior to the kind of discovery that would blackboard specials and non-economic damages. These compromise settlement offers were agreed figures between your policy holders, defense counsels for the named insured, MICA claims management, and the MICA claims committee based on their knowledge of verdict ranges under this jurisdiction. Consent to settle was obtained from the insured in accordance with the policy provisions in effect at the time of the loss. That policy provision is as follows:

B. Settlement and Defense:

The Company shall not settle nor compromise any claim or suit against the Insured, without the consent of the Insured, but the Company shall have the sole and exclusive right to control the defense of any claim or suit irrespective of its amount. Should the Insured refuse to consent to any settlement recommended by the Company after an expert advisory panel appointed by the Court or a review by a panel of physicians or consultants appointed by the Company has found that the Insured was negligent or failed to use due care, the policy limits are reduced to the amount of the settlement recommended by the Company. In no event shall the Company be obligated to pay any claim or judgment after the applicable limit of the Company's liability has been exhausted by payment of judgment or settlement.

In cases where the claims files revealed that economic damages were blackboarded by plaintiff counsel, results were as follows:

Economic Damages

\$ 217,685
\$ 250,000-\$350,000
\$ 207,568
\$ 416,843
\$ 500,000
\$ 73,070
\$1,922,103
\$ 432,000
\$1,162,985

Settlement/Verdict

Defense Verdict
\$ 145,000
\$ 250,000
\$ 150,000
\$ 186,667
\$ 200,000
\$1,950,000/(\$550,000 MICA)
\$ 750,000
\$ 800,000

It is important to remember that most of these figures were not supported by an economist's forecast and in many cases they would be actively challenged by defense counsel if litigation had continued in the case.

Punitive Damages

While punitive damages were often enumerated as part of the damages being claimed in the Summons and Complaint, I found no awards or payments for punitive in the files I reviewed.

Collateral Source

Only one of the cases involved in this study involved a judgment where collateral source was considered in reducing a judgment. In that case it was determined that the plaintiff had received \$21,995 from a private medical care provider. The judgment was reduced by the court in that amount.

As with Rule 82, collateral source payments were often discussed in considering settlement offers and in negotiations, but compromise settlements did not reflect a breakdown of the damages being paid.

Statute of Limitations

I found no cases where suit was filed outside the present statute of limitations. In cases involving infants or mental incompetents, suit was brought within two years following the date of event.

Plaintiff Contingency Fees

For files that reflected the contingency fee agreement between the plaintiff and his attorney I have listed the total settlement, the attorney's contingency percent, and MICA's defense costs. In compliance with your original instructions, where contingency fees are unknown I have listed only the settlement/verdict and the defense cost.

Plaintiff Contingency Fees (Continued)

	<u>Payment*</u>	<u>Contingency</u>	<u>Defense Costs</u>
1.	86-230-02A \$ 100,000	Unknown	\$ 25,000.00
	86-230-02B \$ 100,000		\$ 11,024.00
	other defendants \$ <u>50,000</u>		<u>Unknown</u>
	Total \$ 250,000		\$ 16,664.00
2.	85-190-20 \$ 100,000	Unknown	\$ 2,307.00
	85-186-16 \$ 45,000		\$ 1,437.00
	85-185-15 -0-		\$ 1,218.00
	other defendants <u>---</u>		<u>---</u>
	Total \$ 145,000		\$ 4,962.00
3.	84-131-16 \$ 35,000	Unknown	\$ 67,672.00
	84-132-17 \$ 190,000		\$ 36,360.00
	other defendants <u>---</u>		<u>---</u>
	Total \$ 225,000		\$ 104,032.00
4.	84-116-01 \$ 503,625	Unknown	\$ 18,267.00
	other defendants <u>---</u>		<u>---</u>
	Total \$ 503,625		\$ 18,267.00
5.	76-001 -0-	Unknown	\$ 62,367.00
	76-002 -0-		\$ 48,353.00
	(not reviewed - file not located)		
	other defendants <u>---</u>		<u>---</u>
	Total -0-		\$ 110,720.00
6.	80-041-18 \$ 172,500	Unknown	\$ 85,268.00
	(MICA advanced funds to uninsured physician w/promissory note)		
	other defendants \$ <u>47,500</u> -uninsured physician		<u>---</u>
	Total \$ 220,000		\$ 85,268.00
7.	83-089-04 \$ 98,000	Unknown	\$ 44,209.00
	other defendants \$ <u>42,000</u>		<u>---</u>
	Total \$ 140,000		\$ 44,209.00
8.	85-197-27A \$ 400,000	Unknown	\$ 24,179.00
	85-197-27B -0-		\$ 8,487.00
	other defendants \$ <u>107,000</u>		<u>Unknown</u>
	Total \$ 507,000		\$ 32,666.00

9.	84-121-06	\$ 170,000		\$ 14,983.00
	84-121-07	\$ 30,000		\$ 3,696.00
	other defendants	---		---
	Total	\$ 200,000		\$ 18,679.00
10.	82-075-15	\$ 100,000	Unknown	\$ 3,936.00
	*83-088-03	\$ 25,000		\$ 2,274.00
	other defendants	---		---
	Total	\$ 125,000		\$ 6,210.00
11.	84-138-23	\$ 58,800	Unknown	\$ 37,471.00
	84-141-26	\$ 25,200		\$ 7,507.00
	other defendants	\$ <u>36,000</u>		---
	Total	\$ 120,000		\$ 44,978.00
12.	77-010	\$ 150,000	Unknown	\$ 11,454.00
	other defendants	---		---
	Total	\$ 150,000		\$ 11,454.00
13.	81-060-19	-0-		\$ 978.00
	82-081-21	\$ 229,965		\$ 11,396.00
	other defendants	\$ <u>15,000</u>		<u>Unknown</u>
	Total	\$ 244,965		\$ 12,374.00
14.	84-149-34	\$ 186,667	33% (Kneeland Taylor)	\$ 2,501.00
	other defendants	<u>pending</u>		---
	Total	\$ 186,667		\$ 2,501.00
15.	82-071-11	\$ 80,000		\$ 9,941.00
	82-072-12	\$ -0-		\$ 3,160.00
	82-073-13	\$ 80,000	Unknown	\$ 4,941.00
	other defendants	\$ <u>40,000</u>		---
	Total	\$ 200,000		\$ 18,042.00
16.	82-069-09	\$ 50,205		\$ 15,235.00
	82-070-10	\$ 50,205		\$ 15,227.00
	other defendants	\$ <u>100,000</u>		<u>Unknown</u>
	Total	\$ 200,410		\$ 30,462.00
17.	82-067-7	\$ 150,000	Unknown	\$ 21,933.00
	82-065-5	\$ 150,000		\$ 24,914.00
	other defendants	---		---
	Total	\$ 300,000		\$ 46,847.00

18.	83-098-13	\$ 333,667	Unknown	\$ 25,379.00
	other defendants	\$ <u>166,833</u>		<u>---</u>
	Total	\$ 500,000		\$ 25,379.00
19.	77-012	\$ 200,000		\$ 11,288.00
	78-014	\$ 50,000		\$ 774.00
	other defendants	<u>---</u>		<u>---</u>
	Total	\$ 250,000		\$ 12,062.00
20.	83-091-06	\$ 550,000	Unknown	\$ 32,665.00
	other defendants	<u>\$1,400,000</u>		<u>---</u>
	Total	\$1,950,000		\$ 32,665.00
21.	83-112-27	\$ 750,000		\$ 13,207.00
	other defendants	<u>---</u>	Unknown	<u>---</u>
	Total	\$ 750,000		\$ 13,207.00
22.	84-143-28	\$ 312,500	20% fee (Ames Luce) (would have increased to 40% if tried)	\$ 12,171.00
	other defendants	\$ <u>362,500</u>		<u>Unknown</u>
	Total	\$ 675,000		\$ 12,171.00
23.	85-218-48	\$ 800,000		\$ 6,498.00
	other defendants	<u>---</u>		<u>---</u>
	Total	\$ 800,000		\$ 6,498.00
24.	83-106-21	\$ 99,335		\$ 73,124.00
	other defendants	<u>---</u>		<u>---</u>
	Total	\$ 99,335		\$ 73,124.00
25.	84-134-19	\$ 75,000		\$ 58,321.00
	other defendants	<u>---</u>		<u>---</u>
	Total	\$ 75,000		\$ 58,321.00
26.	85-214-44	\$ 175,000		\$ 10,878.00
	other defendants	<u>---</u>		<u>---</u>
	Total	\$ 175,000		\$ 10,878.00
27.	85-195-25	\$ 163,500	33% (Ray Matthews)	\$ 39,417.00
	other defendants	\$ <u>10,000</u>		<u>---</u>
	Total	\$ 173,500		\$ 39,417.00

28.	86-244-16	\$ 512,750	33% (Bernard Kelly file note 40% if tried)	\$ 1,639.00
	other defendants	---		---
	Total	\$ 512,750		\$ 1,639.00
	Total Payments	\$9,678,252	Total Defense Cost	\$ 893,696.00

* Payments from other defendants is reflected if known and noted in the claim file.

NOTE: In some cases defense costs noted in the file reviews were slightly different than those reflected on MICA financial documents. In these cases I have relied upon figures reflected on the financial documents.

Periodic Payments

I found no court ordered periodic payments evident in the files I reviewed. There was considerable effort shown by MICA claims management in attempting to reduce MICA's payments to the plaintiff by offering structured settlements.

Annuities were quoted and offered as part of the settlement package in nine of the cases I reviewed. Five settlements included annuities. The files reflected that plaintiff counsel was cognizant of the purchase price of the annuity through independent sources. While financial benefit was derived by MICA by utilizing annuities as part of settlement packages, the savings were generally a fraction of the total payments to the plaintiff over the life of the annuity.

SUMMARY

Unless cases are tried and the judgments broken down per section 09.17.040 of the 1986 Tort Reform Act, non-economic damages are going to be difficult to capture.

MICA files reveal continuing legal arguments to attempt to clarify the legislative intent of periodic payments and collateral source statutes in cases where they have been considered. It appears that the effect of the revised statutes on rates will ultimately be determined by Supreme Court interpretation.

RESUME OF JOYCE WAINSCOTT

Joyce Juel Wainscott (Bach)
P.O. Box 1589, Eagle River Road
Eagle River, Alaska 99577

(907) 694-2407 (H) (907) 562-3333 (W)

I. EMPLOYMENT:

1/88 to present Professional Adjusters of Alaska Inc.
3900 Arctic Blvd., Suite 104
Anchorage, Alaska 99503

Title: Casualty Insurance Adjuster

Responsibilities: Investigation, negotiation, and settlement of casualty claims.

7/73 to 11/87 CIGNA
2525 C Street, Suite 400
Anchorage, Alaska 99503

Responsibilities: Progressively responsible positions including:

Claims Manager. Duties: Claims severity control, productivity and expense control, allocated/unallocated budget development and administration, and human resource management for CIGNA claims in the State of Alaska. All lines of commercial and personal casualty and property claims.

Served as Alaska Pacific Assurance Company Corporate Secretary.

Claims Operations Manager. Duties: Responsible for management of claims operational staff to include budget development and administration, work flow systems, training and development of staff. Position included facility management for all claims, underwriting, marketing, loss control in Alaska.

Provided support in handling the Alaska Guaranty Association.

Assistant Manager, Field Operations. Duties: Responsible for management of a staff of fifty + operational employees performing support duties in all phases of insurance production and claims administration; financial, claims, policy rating, general clerical, files, personnel, and loss control.

Position included facility management of a 35,000 square foot office building and grounds under a triple net lease, including sub-leases and tenant improvement and management.

Claims Unit Manager - Worker Comp. Duties: Responsible for the management of a unit of 25-30 claims professional and clerical employees processing Alaska Workers Compensation, Longshore, and Jones Act Claims. Job duties included job development, technical training, work flow management, human resource management, development and administration of a budget.

Responsible for direction of subrogation for all worker's comp claims.

Claims Supervisor - Casualty. Duties: Supervision of Anchorage claims professional and clerical department in the adjusting of auto, general liability, inland marine, and cargo commercial losses. Coordinated all litigated cases. Assigned losses, provided technical training, administered salary programs. Developed claims coding training manuals for computerization of claims records.

Responsible for reinsurance reporting for claims for Alaska Pacific Assurance Company in ten offices nationwide.

Claims Adjuster. Duties: Responsible for the investigation, negotiation and settlement of auto, G.L., and I.M. claims.

Directed defense counsel in litigated cases and provided clerical direction for specific lawsuits.

II. EDUCATION:

<u>School and Location</u>	<u>Curriculum or Major</u>	<u>Date</u>	<u>Degree</u>
Montana State Univ.	History/Education	1966-1969	No
University of Alaska	History/Education	1969-1971	Bachelors
Graduate School University of Alaska	Education Classes	1972	No

DEVELOPMENT PROGRAMS

<u>Development Program</u>	<u>Subjects Covered</u>	<u>Date Completed</u>
Legal Principles	Basic Tort Law	1976
Tort Law - Univ. of Alaska	Tort Law	1977
College of W/C (San Fran.)	Mgmt. of Industrial Claims	1977
ICA - Defending the Modern W/C Claim (San Fran.)	Creative Defenses to W/C Claims	1977
Front Line Management	Management Skills	1977
Defense Institute Claims (San Francisco)	Legal Mgmt. of Claims	1978
Law for the Claimsman	Liability Law/Defenses	1978
11A - Part II - Univ. of Alaska	Property Coverages	1978
The Woman Manager	Achieving Success as a Manager	1978
USLH Coverages	Jurisdiction Clarification	1979
I CARE Seminar	Improving Business Relationships	1979
Advanced Negotiations	Improving Negotiation Skills	1979
Jones Act Coverages	Jones Act Coverages /Defense	1980

IST - Train the Trainer	Supervisory Skills Certified to Teach Front Line Supervisors	1981
Targeted Selection	Interviewing Skills and Techniques	1981
Problem Solving/Decision Making	Cause Analysis, Decision Making, Problem Solving	1985
Product Liability	Investigation/Settlement of claims arising out of product liability	1986

III. PERSONAL INFORMATION

Height: 5' 10"
 Weight: 155
 Date of Birth: 6/13/48
 Marital Status: Married
 Hobbies: Fishing, Reading, Scuba Diving, and Travel.

IV. PROFESSIONAL MEMBERSHIP

Soroptomist's International of Anchorage.

V. REFERENCES

Available upon request.

ADDENDUM 1

COMMENTS ON COMPUTER DATA BASE/CODING

Explanation of columns

Column 1.

Coding indicates whether the claim is a physician claim, hospital claim or a related health care facility claim.

Column 2.

The file number shown is MICA's claim file number.

Column 3.

Severity code 5 indicates a matter in suit.

Severity code 4 indicates a matter in which a formal claim has been asserted against the insured's policy but which has not progressed to litigation.

Column 4.

P = Pending

C = Closed

In our operation at MICA we keep a file open until all financial transactions are complete. In the case of subrogation, pursuit of reinsurance contribution, or other salvage operations this may appear to skew our data. Frequently settlement or conclusion of the liability aspects of the file occur significantly earlier than actual file closure. At the present time our data base does not differentiate between conclusions of liability issues and closure of the file with finalization of all financial transactions.

Column 5.

D/O refers to the date of occurrence or the date on which the care in question took place. The date of occurrence is represented in full on our computer base but I have irradiated the day and the month leaving only the year in which the medical care was rendered for the sake of confidentiality.

Column 6.

D/R refers to the date the insured reports the matter to MICA. This is not necessarily the date on which a claim is made or suit is filed. In earlier years that was frequently the case since our insured physicians and hospitals did not notify the company of problems in their practice until and unless a formal claim was asserted or they received service of a summons and complaint. In recent years insureds have become more sophisticated on the value of early reporting of high risk occurrences. So you should see a shortening of the gap between date of occurrence and date of report in recent years and you can assume that many things are being reported prior to a formal claim being asserted or a law suit being filed. Our computer base gives this date including the day and the month. I have irradiated that information leaving only the year of the report.

Column 7.

Date of Claim: Again, I would point out that we have only recently begun to emphasize the necessity of early reporting of high risk occurrences. We are now seeing enough of that that we feel a need to begin to differentiate between the date the doctor or hospital actually reported the matter to MICA and the date on which a formal claim was asserted or a law suit filed. This is a new informational column on our data base and while we are tracking it from the present day forward you will see that it has not been tracked in the past in most instances.

Column 8.

The date of closure is the date the file was actually closed in the MICA office.

Column 9.

Date of reopening: On rare occasions a closed file is reopened. This column captures any such reopenings.

Column 10.

Date of final closure: In the event a closed file is reopened this column is designed to capture the last closing date.

Column 11.

S.O.L.: This column is another new column in our data base. We are tracking this information from the present into the future but you will not find it on all past entries. The column is meant to capture the date on which the statute of limitations runs. It is not designed to capture any information about the use of a statute of limitations defense.

Column 12.

Total paid all years.

1. **Loss** - This is the monetary amount that was spent as the indemnity payment on the file.
2. **LAE (Loss Adjustment Expense)** - This is the amount of money expended in the defense of this case.

Our LAE figure reflects not only defense attorney costs and fees but a variety of other expenses in the defense of a file including preliminary medical reviewers, medical experts, depositions, etc. Every penny spent on preparation of the defense of this case is accounted for in this one column. I would caution you against assuming that the total figure reflects defense attorney fees.

Keep in mind that on files coded as "C" (closed) the figures for both indemnity and expense are final.

In files coded as "P" you can assume that the indemnity figure if it changes at all will diminish due to reinsurance contribution, recovery from subrogation, etc. Conversely cost of defense, if they change at all, would likely increase.

Addendum 2

	Number	Total Average Cost	Average Indemnity	Average Expense	c/\$ Defense
<u>Claims (Severity Code 4)</u>					
Pending With Indemnity Paid	4	\$11,810.25	\$11,450.74	\$359.51	3c
Closed With Indemnity Paid	43 (37%)	\$68,009.39	\$65,590.00	\$2,418.45	4c
Closed Without Indemnity Paid	72 (63%)	\$1,663.47	0	\$1,663.47	100c

<u>Suits (Severity Code 5)</u>					
Pending With Indemnity Paid	6	\$310,868.67	\$241,239.58	\$69,629.09	22c
Closed With Indemnity Paid *	68 (40%)	\$261,068.02	\$227,054.23	\$34,013.79	13c
Closed Without Indemnity Paid	100 (60%)	\$10,640.50	0	\$10,640.50	100c

*66 settled
2 tried and lost

Addendum 3

Liability Survey

Claim Synopsis

1. Date of event: See Column 5 of computer data base.
2. Date suit filed: Not captured on MICA's data base. (In earlier years the date on which suit was filed and the date on which the matter was reported to MICA tended to be very close to one another. In later years the date of report to MICA may frequently antedate the date on which suit is filed.)
3. Date case settled/verdict received: Not available from data base. (Date of file closure reflects date of conclusion of all financial transactions which may be some time after the settlement of a case or a verdict.)
4. Statute of Limitations: The data base does not track this. Joyce Wainscott, in her 1988 study, found no cases where suit was filed outside the present statute of limitations. Since that time we have had two suits filed outside the statute of limitations. In one instance the plaintiff is alleged to be mentally incompetent and that is the reason for the tolling of the statute. In the other instance we successfully used a statute of limitations defense and the court disposed of the case on our motion for summary judgment.
5. Percentage of comparative negligence: Case evaluation also includes analysis of allocation of responsibility as between plaintiff and defendant(s). In cases concluded by settlement this is an obvious negotiating issue. In cases tried it is an obvious issue. One concern: In the spirit of true assessment of contribution it would be desirable to have all parties who contributed to the outcome in the case.

In Justice v. Humana subsequent health care providers in another state had settled but for a relatively modest amount and with a kick back provision designed to reimburse approximately 50% of their settlement from proceeds of the Alaskan lawsuit. The Alaska jury, wishing to assign the majority of responsibility to the out-of-state providers, asked the judge to whom they could assign comparative. They were instructed that 100% of the negligence had to be divided between Mr. Justice and Humana Hospital. Three attempts by defendant to have the out-of-state hospital named as a party in interest to this suit had been unsuccessful. Consequently the Alaskan hospital paid approximately six times what the California hospital paid.

6. Total payment: Reference columns 8 and 9 of the computer data base for total loss and LAE payments.
7. Payment by each co-defendant: Please reference Joyce Wainscott's report which tracked this information, insofar as it was available in MICA files, through the Spring of 1986. I have not gone through files closed from April of 1986 to the present time to extract this information by hand. Our closed files are on microfilm and this would be a very time consuming process which would create quite a burden on our existing staff resources. Since MICA insureds the majority of both physicians and hospitals in the state of Alaska it is not uncommon that we will insure more than one defendant in a law suit. When and if that is true we know with certainty what was paid by a co-defendant. If that is not the case we are apt not to know what is paid by a co-defendant, particularly when that payment comes at a point in time after the termination of our involvement in the case.
8. Collateral source: Ms. Wainscott cited one case involved in her study that involved a judgment where collateral source was considered in reducing the judgment. Since that time there has been one other case when the court offset collateral payments in rendering judgement.

I would say that the statement made by Ms. Wainscott as regards consideration of collateral source payments in consideration of settlement offers and negotiations is as true today as when she wrote it. Collateral sources are very much considered in case evaluation and settlement negotiations but they are not always or usually broken out in our file and are frequently used as bargaining issues. As I am sure you are aware jury awards are frequently not itemized either.

9. Same answer as number 8.
10. Case evaluation (If 100% liable): I am not entirely clear as to your request here. You could be requesting information on the indemnity reserve that we put on a case if we think we are 100% liable. I am assuming, however, that you mean how many cases do we feel that our insured is totally responsible for. Or put in another way, how frequently do we admit liability and simply work on evaluating the damages. This is not data captured on the data base. I have been with MICA for a long time and I think I am fairly knowledgeable about cases since the company's inception as well as those that I have managed. To the best of my knowledge we have never gone into court and simply admitted liability and tried a case on damages alone. A very small minority of our cases are cases where I feel that we are dead in the water on issues of liability and are 100% liable.

There are certainly cases where we feel our insured is liable but, most often, there is also liability on the part of other health care providers or contributory negligence on the part of the patient.

Damages

1. Medical Specials: Our data base does not reflect this information. In evaluating a case where settlement or in preparing a case for trial we do assess the medical specials as well as collateral sources of payment.

2. Economic Specials/Income: Again, this information is not available through the data base but is collected in the process of evaluating a case for settlement or preparing a case for trial.
3. Economic Specials/Outgoing: I do not know what you mean here.
4. Pain and Suffering: The information is not available on the data base. We have had only one case tried to a plaintiff verdict since Ms. Wainscott's study was completed. All of the figures for that are appended. We do consider pain and suffering in reserving our cases.
5. Disfigurement: See the explanation for 4. above.
6. Loss of Enjoyment of Life: See 4. above.
7. Punitive Damages: To my knowledge punitive damages have never been awarded against a MICA defendant.
8. Loss of Consortium: Again, very few MICA cases have been tried to a plaintiff verdict and I do not know of any loss of consortium award.
9. Other: I have nothing further to specify.
10. Prejudgment Interest: In addition to the information presented in Ms. Wainscott's report we have only the one case tried to a plaintiff verdict and the information is appended.
11. Post Judgment Interest: See the appended sheet where the one case tried to a plaintiff verdict since Ms. Wainscott's report.

Method of Payment

I have little to add to Ms. Wainscott's report. There have been no court ordered periodic payments evident in the MICA files.

The MICA Claims Management continues to offer and utilize structured settlements whenever they are acceptable to plaintiffs.

Attorney Fees/Costs

1. Contingency Fee/Percentage Plaintiff: I would refer you to Ms. Wainscott's report. Since that time one case has been tried to a plaintiff verdict and a variety of cases have settled. In settlement it is not necessarily evident to the defendant what the contingent fee arrangement is between plaintiff and his or her legal counsel. The statistics on the one case tried to a plaintiff verdict are attached.
2. Rule 82: I have little to add to Ms. Wainscott's evaluation of last year. The one case tried to a plaintiff verdict resulted in payment of Rule 82 attorney fees and that information is appended. Rule 82 attorney fees are a matter for consideration in policy limit settlements. MICA policy language has changed somewhat in the last three years to protect against payment of Rule 82 attorney fees on the projected value of the case were it taken through trial.
3. Cost/Plaintiff: Again, we have only had one case tried to a plaintiff verdict in the last two years. The costs in that case are in the appended information. As I am sure you know court awarded costs are not reflective of the real costs.

So even if we have a variety of cases tried to verdict with award of costs to the prevailing party it would be difficult to ascertain another party's costs.

4. Defense Costs:
5. Defense Fees: This information is available in the far right hand column of the data base. Again, I would caution you that this lump sum includes not only defense attorney costs and fees but all of the costs of the defense of the case including medical experts, depositions, computer research, etc.

STATE OF ALASKA

OFFICE OF THE GOVERNOR

OFFICE OF MANAGEMENT AND BUDGET

August 31, 1989

DIVISION OF POLICY

STEVE COWPER, GOVERNOR

P.O. BOX AD- RECEIVED
JUNEAU, ALASKA 99811-0199
PHONE: (907) 465-3568

MICA

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

Dear Ms. Pierce:

As discussed earlier this week, I am providing you with a list of questions concerning medical malpractice claims in Alaska that I hope you can help us answer. We are interested in obtaining basic historical information on claims in Alaska, in order to place the upcoming discussion on the Governor's Claims Board legislation in context.

Specifically, we would like to know, for the years 1984 through 1988:

- 1) the number of incidents reported to MICA against health care providers each year (by type of error, if possible: surgical, diagnostic, treatment, obstetrical, other);
- 2) the number of claims filed with MICA against health care providers each year (by type of error, if possible);
- 3) the number of claims closed each year, with indemnity payments and without, and the reasons for those closed without payment;
- 4) the average and the median amount of indemnity payment by MICA each year;
- 5) the total indemnity payments paid out by MICA each year, in the following categories: less than \$1000; \$1000 - \$4999; \$5000 - \$9999; \$10000 - \$24999; \$25000 - \$49999; \$50000 - \$99999; \$100000 - \$249999; \$250000 - \$999999; and \$1 million or more;

6) the severity of the injuries for which claims were filed, for the five year period, according to the following categories: emotional; insignificant; temporary disability - minor; temporary disability - major; permanent partial disability - minor; permanent partial disability - major; permanent total disability - major; permanent total disability - grave; and death.

✓ 7) the number of claims by type of facility where injury occurred (hospital, physician's office, and other) each year; and

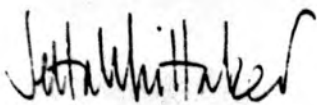
8) the average and median number of health care providers involved in claims, for the five year period.

I hope that answers to these questions are not difficult to generate. You mentioned during our conversation that you had prepared some documents for Representative Donley of the House Labor and Commerce Committee last session. If any of that existing information comes close to answering the above questions, and thus would save you additional work, we would be satisfied with those reports. If some of this is easier to answer than other parts, please send us data as it comes available.

At this point, we are not looking for information or projections on how the Governor's proposal might affect the medical malpractice market. We anticipate such need in the future, however, and look forward to working with you on developing projections.

Thank you for your cooperation and assistance. Please feel free to call me if you have any questions about this request.

Cordially,



Jetta Whittaker

MICA Medical Indemnity
Corporation of Alaska

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

Jetta Whittaker
State of Alaska, Office of the Governor
P.O. Box AD
Juneau, Alaska 99811-0199

Dear Ms. Whittaker,

I received your letter on September 5th outlining the information you felt you needed immediately on MICA claims history. We have provided that information here as best we possible could in a short time frame. I've incorporated narrative support explanation to the attached data below.

- 1.) We are in the process of imputing "type of error" information on all previous claims. This is a large task and has yet to be completed. We should be able to do that sort for you in about a month. What is included here is the number of incidents reported.
- 2.) We have done the same for claims/suits, as we've shown for incidents in #1. We designate occurrences by a severity level code 1-5. Code 1, 2, and 3 are reported incidents. Code 4's are claims which we distinguish from an incident because a formal written demand has been made. Code 5's are lawsuits. This coding is in compliance with our insurance policy contract wording and our reinsurance contract, and has nothing to do with the severity of the incident.
- 3.) To answer this question we have had to provide you with a matrix. Malpractice by its nature is what we term in the industry "long tail" business. It is extremely unusual to open a claim and close it out all in the same year. For instance you will note that in 1984 only one 1984 claim was closed in that same year (with indemnity paid). In 1985 we closed on a 1978 case.

I have no way short of looking at every file to tell you why a claim closed with no indemnity payment. We can do that but it will mean we have to pull every file and it was too time consuming to accomplish quickly. If you do want this done please let me know. In general no indemnity payment is made because the plaintiff recognizes that there is no liability.

- 4 & 5) I've combined the answer to 4 and 5 into one table. The average and median amount of indemnity payment by MICA each year is not a statistically creditable piece of information. One reason is we are paying out previous year's claims (as I explained in number 3 above) and secondly we don't have enough claims to generate meaningful data on an annual basis. I've stratified our payments since inception and included average claim and average claim where we paid indemnity for all our history.

Medical Indemnity Corporation of Alaska

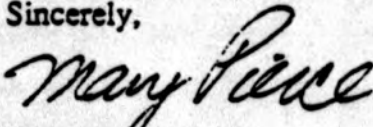
5.) We do not categorize our claims by the severity of injuries you've requested and I'm not able to answer this question.

7 & 8) I've combined the answer to 7 and 8 by breaking down claims between types of providers; physicians, hospitals and related healthcare facilities. The average and median number is displayed for each provider group and the total average and median for all providers. I wouldn't rely on the statistical credibility of these figures because we have so few providers.

I'm also sending you a copy of a letter we received earlier this year from the Department of Health and Social Services requesting historical obstetrical claims experience. Since this is an area of concern for us as well as most providers I thought you might find our answers helpful.

We have answered your questions as best we could in a short time frame. We remain willing to provide more complete information as you request it and time allows.

Sincerely,



Mary Pierce
Executive Director

MP/sm

1

MEDICAL INDEMNITY CORPORATION OF ALASKA**NUMBER OF INCIDENTS REPORTED WITH SEVERITY CODE 1,2,3**

<u>YEAR OF OCCURRENCE</u>	<u>NUMBER OF INCIDENTS</u>
1984	30
1985	76
1986	151
1987	127
1988	69
	453

2

MEDICAL INDEMNITY CORPORATION OF ALASKA**NUMBER OF INCIDENTS REPORTED WITH SEVERITY CODE 4,5**

<u>YEAR OF OCCURRENCE</u>	<u>NUMBER OF CLAIMS/SUITS</u>
1984	41
1985	43
1986	43
1987	34
1988	17
	178

#3A

MEDICAL INDEMNITY CORPORATION OF ALASKA

CLAIMS CLOSED WITH NO INDEMNITY PAYMENT (SEVERITY CODE 4,5)

CLAIM MADE	CLAIM CLOSED				
	1984	1985	1986	1987	1988
1976					
1977					
1978		1			
1979					1
1980	1	1			
1981	1	1			
1982	5	1	3	3	
1983	4	3	2	3	
1984	1	4	3	4	4
1985		6	7	18	8
1986			2	5	7
1987				6	13
1988					7

#3B

MEDICAL INDEMNITY CORPORATION OF ALASKA

CLAIMS CLOSED WITH INDEMNITY PAYMENT (SEVERITY CODE 4,5)

CLAIM MADE	CLAIM CLOSED				
	1984	1985	1986	1987	1988
1976					
1977					
1978		1			
1979					
1980		1		1	
1981	1				
1982	5	2	3	2	1
1983	4	3	1	1	
1984	1	5	7	5	1
1985		2	6	5	7
1986			4	6	3
1987				2	3
1988					2

#4 & 5

MEDICAL INDEMNITY CORPORATION OF ALASKA ALL CLAIMS - INCEPTION THROUGH 1988 BY PAYMENT SIZE

INDEMNITY PAYMENT	# OF SUITS/CLAIMS	PERCENTAGE
0	165	62
1-1,000	6	2
1,001-5,000	14	5
5,001-10,000	12	4
10,001-25,000	14	5
25,001-50,000	17	6
50,001-75,000	7	3
75,001-100,000	10	4
100,001-150,000	6	2
150,001-200,000	8	3
200,001-500,000	4	1
500,001-750,000	4	1
750,001-2,000,000	2	1
2,000,001-3,000,000	2	1
	271	100

Average Claim - \$48,731

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