

ALASKA LEGISLATURE SPECIAL COMMITTEE/SUBJECT FILE 8672
1756 SCOMM 69: HOUSE LIABILITY INSURANCE TASK FORCE, 1989-1990 324

Recommendation: [No. 2]:

Any award to which the injured patient is entitled should be reduced by all available collateral sources such as private, group or governmental medical or disability benefits whether contributory or noncontributory, except life insurance, by precluding the introduction into evidence of the items of damage compensated by collateral sources, except federal programs which by law must seek subrogation.

Control of Legal Fees

The Commission addressed the issue of attorneys' fees, which, unfortunately, has become one of the more emotional issues in the malpractice situation.

Contingency fees, or fees based upon the size of the award, have become highlighted because of the size of the few cases in which lawyers have been successful in obtaining substantial awards. The Commission found, however, that the overall remuneration of attorneys that engage in this type of practice is not unduly high when the cases which require substantial effort and result in defense verdicts or in modest plaintiff's verdicts are considered.

Further, contingency fee arrangements may often be the only way that injured persons can obtain separation because of their inability to compensate the lawyer on a regular time fee basis.

Nonetheless, the Commission recognizes that a significant element in the cost of the system is the fee for both plaintiff and defense lawyers.

The court rules of Alaska, Rule 82, already make provision for court involvement in the matter of legal fees. The Commission believes that the court should go further and exercise its authority to more carefully review attorneys' fees actually paid to both plaintiff and defense lawyers. The same principle should apply in proceedings before the adjudication board discussed below.

Precluding Certain Liability

Several examples which came to the attention of the Commission where the concern for exposure to possible litigation overrode the doctors' concern for the life and health of either patients of that doctor or persons requiring immediate medical service with whom the doctors came in contact.

For example, emergency cardiac arrest of a patient in a hospital requires immediate remedial action to resuscitate the heart. Normally, the closest medical professional rushes to the bedside and administers aid. Because of the potential malpractice exposure to the administering medical professional if, in the haste to save a life, the professional errs in the rendering of such care or is too late to permit resuscitation to be totally rehabilitative, doctors are "walking slow" in response to such emergencies. To encourage the rendering of critical emergency care the Commission recommends:

Recommendation: [No. 3]

Medical professionals should be immune from liability to a person who is not his patient for administering emergency medical care where

the giving of immediate aid appears to be the only alternative to death or serious bodily injury or harm.

Doctors cited several examples of actions brought by patients who were treated properly but who did not achieve the state of medical health which the patient regarded as promised by the treating physician. These actions were brought, not for medical negligence, but for breach of warranty or for breach of a contract to achieve a specific result.

There are circumstances where the doctors do make a promise of a specific result and where it would be appropriate to permit liability where the promised results are not obtained. On the other hand, the doctor is entitled to at least the protection of requiring a quantum of proof that precludes any claim of a promise to achieve a specific cure in circumstances where no promise was actually intended. Accordingly the Commission recommends:

Recommendation: [No. 4]

The law should provide that no promise to achieve a certain medical result is valid unless that promise is in writing signed by the health care provider.

Defining the Standard of Care

One of the thorniest issues posed to juries is the definition of the standard of care by which health care providers' conduct is adjudged.

In 1967, the Alaska legislature adopted a statutory definition of the standard of care that an injured patient was required to prove in a malpractice case. That statute, AS 09.55.530 et. seq., is a more clearly defined standard than exists today in many states. Nonetheless, it requires further refinement to make the standard more relevant to the higher standard of medical service available in the State today and to establish more appropriate conditions upon actions for medical negligence. The Commission believes that the standards to which Alaska health care providers must adhere should be the national standard of acceptable medical care; it is no longer necessary or appropriate to measure the performance by a local community standard. The Commission recognized, however, that at trial, the standard should be measured taking into account the time and circumstances under which the act or omission complained of was incurred. The Commission, therefore, recommends:

Recommendation: [No. 5]

The definition of medical negligence be improved by adopting a national standard of acceptable medical care in lieu of a local community standard, limiting the standard to that at the time of the act, and imposing the standard appropriate under all circumstances under which the health care provider was acting.

Burden of Proof

The Commission received numerous suggestions for modifying the burden of proof from the current requirement that the plaintiff or injured patient

must prove his case by a preponderance of the evidence to a standard more demanding of the plaintiff. The reason for such suggestion was assuring that the case against a health care provider was sufficiently proved by available creditable evidence that spurious or genuinely doubtful cases are precluded.

Over the years, the current test applied in all negligence cases has served well and the Commission does not believe it warranted to carve out a special exception in medical cases which would make it more difficult for the legitimate cases to be adjudicated.

On the other hand, as previously noted, the Commission believes special treatment ought to be accorded claims which are brought over three years after the date of occurrence. Several reasons suggest the justification for applying a more rigid rule to those cases. First, where the case is not discovered for over one year after date of incident, the degree of harm or pain to the patient is often of lesser severity than in cases where the negligence is obvious from the outset.

Second, the more delayed the trial is from the date of incident, the more likely it is that the evidence relevant to the case is destroyed, stale, or not subject to verification. For example, X-rays and many hospital records are destroyed after several years. More importantly, however, a deferred trial date means that the testimony from witnesses, experts and the defendant doctor becomes more clouded by conjectures and lack of clear recollections. This has the potential effect of submitting to the jury a case based on inexact or incomplete testimony and evidence, allowing the

most lay jurors have difficulty understanding.

In a typical medical negligence case, the determination of appropriate medical procedures are matters which jurors must decide after hearing testimony from expert medical technicians which are paid to testify by the parties to litigation calling them as witnesses. The testimony, therefore, is generally conflicting and often equally persuasive.

Most medical negligence cases require substantial and expensive pretrial preparation including extensive discovery and investigation. Often the parties proceed believing their own medical experts, whereas an independent impartial expert opinion might encourage settlement or resolution prior to the lengthy, expensive and often traumatic pretrial proceedings.

Two reasons, then, suggest the advisability of interjecting an expert medical advisory panel into the trial proceedings to aid the jury in resolving conflicting medical testimony and to provide the parties with an early expert opinion.

The function of an expert panel would be to analyze all available technical documentary evidence and to interview and examine the plaintiff, interview the defendant doctor and other experts and to initiate their own review of the circumstances in an informal, yet thorough, manner and issue a report to the parties concerning their conclusions as to medical facts.

To carry out this function effectively, the Commission perceives the panel as composed of at least one physician and two other health care providers of the same discipline as the health care provider charged. The panel would be

appointed jointly by the court and the parties pursuant to carefully delineated procedures, immediately after filing of the case and prior to any discovery or other proceedings in the litigation. Special procedures would be adopted for cases involving multiple defendants.

-----The findings of the expert panel, which would include a determination of the appropriate standard of care, whether the health care provider violated that standard, and the measure of injury resulting from the medical negligence, would be given to each of the parties before they could proceed with pre-trial matters. If the case proceeded to trial, the findings of the panel would be admissible into evidence and the panelists available for cross-examination.

Recommendation: [No. 7]

There be enacted provision for appointment of ad hoc medical expert panels composed of at least one physician and two health care providers of the same discipline as the health care provider charged, impanelled after filing of an action and prior to any pretrial proceedings, to initiate an investigation of available evidence and report to the parties its findings as to medical facts.

Recommendation: [No. 8]

The findings of the expert medical panel be admissible as evidence and the panelists subject to cross-examination in any subsequent trial.

Use of Medical Adjudication Board

Probably one of the most significant contributors to the high cost of the medical negligence reparation system is the expense of the proceedings necessarily incurred when a jury trial is involved.

To properly prepare a case for jury trial more elaborate presentations of medical testimony must be readied. Trials are long because of the procedural care taken in the admission of appropriate evidence. Substantial administrative expense is incurred in the use of State personnel and in jury costs. Comment has already been made of the difficulty of requiring a jury to deal with medical technology with little or no prior preparation.

These considerations led the Commission to explore a variety of other methods of determining the facts of a case. Included were arbitration, screening panels, State administrative hearing procedures, and other similar alternatives.

The Commission rejected any mechanism that required a total review of the evidence and the making of findings and awards, if there was preserved the right of a subsequent trial de novo before another tribunal.

Screening panels and nonbinding arbitration for example generally permitted the parties to proceed to a rehearing before a jury resulting in a duplication of expense rather than a saving of expense.

The Commission also rejected any system that requires the establishment of a whole new governmental agency. The frequency of cases expected to be brought for medical negligence are expected to remain so relatively few that a new agency seems unjustified.

-Voluntary binding arbitration was analyzed and found to be a procedure of considerable merit. In many states provisions have been made in the law which allow the health care provider to require an arbitration agreement before treatment.

The law in Alaska today is such that agreements to submit controversies to binding arbitration are legal if the agreements are not obtained under duress. The Commission believes that the law in this regard should not be changed, and that the medical professions should explore wider use of arbitration agreements.

The Commission has, therefore, recommended:

Recommendation: [No. 9]

There be established a medical adjudication board consisting of nine citizens of the State who are neither health care providers nor legal professionals, nor insurers, and three physicians appointed by the Governor, and one Superior Court judge assigned by the court. This board would be the exclusive tribunal for medical negligence cases.

Recommendation: [No. 10]

Upon the filing of a claim with the Medical Adjudication Board ,
the case be assigned to a Hearing Committee consisting of
three of the citizens, one of the physicians and the judge who
shall hear and finally determine the case.

A committee of five is believed adequate for a proper hearing of the type envisioned, yet a larger board from which the specific committee is chosen is necessary in order to permit rotation, assure availability and preclude persons sitting on cases in which they may have a conflict of interest.

It is appropriate to have a fixed board of thirteen, however, in order to permit the persons responsible for hearing medical negligence cases to acquire skill and also because the board would be expected to have sufficient continuity to enable it to enact rules of procedure and to oversee the administration of these cases within the judicial system.

In order to assure due process, judgments of the committee of the board would be appealable to the Supreme Court in the same manner as appeal from a jury verdict.

It is envisioned that the procedures before the board would be greatly simplified and that the use of the expert medical panel would continue before the board proceedings as it is now recommended it function before a jury trial.

It is further believed that such a board procedure will accomplish the desirable result of making the system more accessible so that persons could seek and obtain a just result without the necessity of a lawyer and so that small cases could be handled with sufficient economy that persons with small but legitimate claims could be compensated.

Constitutionality

The State Attorney General expressed the opinion to the Commission that the concept of the Medical Adjudication Panel would violate the Alaska State Constitution unless access to the jury was ultimately available to the parties.

The Commission firmly regards it inappropriate to establish an administrative procedure for determining those matters and then dilute the effect of the tribunal's findings and compound the expenses by allowing a retrial of the matter before a jury. Therefore, the Commission recommends:

Recommendation: [No. 11]

The legislature enact a joint resolution for the amendment of Article I, Section 16 of the Alaska State Constitution, permitting the legislature to consider an alternative system of adjudicating medical negligence claims which may be a substitution for trial by jury.

The Commission recognizes that the constitutional amendment and, thus the

medical adjudication panel, cannot be enacted before the general election in 1976. All other phases of the Commission's proposal, however, including the provisions for a medical expert panel, can be enacted and implemented immediately and would require no subsequent changes when the Medical Adjudication Board becomes a reality.

Periodic Payments

The Commission evaluated the equity of awarding lump sum benefits to an injured patient and found that there were inequities in granting lump sum awards and considered available alternatives.

Several examples were received in which a substantial award was conferred upon a person severely injured based primarily upon a life expectancy of many more years than the plaintiff could reasonably be expected to actually live in view of the medical situation.

The large award for reasonably anticipated lifetime medical care and reimbursement for loss of future earnings is reasonable and not questioned by the Commission even though the awards necessary to compensate for these damages were frequently unusually large. What does become an inequitable charge to the system is the windfall to heirs or others if the patient-plaintiff dies shortly after the award is made. It is also inequitable for a person who outlives the projected life span to be left destitute because the funds ran out.

Periodic payments and annuities are not prohibited now in Alaska where the

cases are settled prior to trial. The Commission believes, however, that the substantial value of permitting periodic payment plans requires that it be encouraged for the distribution of jury or board awards.

Recommendation: [No. 12]

Provisions be made to authorize and administer the awards of future income and continuing medical care to be paid periodically rather than in a lump sum.

Itemized Awards

The juries are currently awarding damages in a single indivisible verdict, even though the damages alleged are for different categories of loss. Much of the proposal of the Commission contemplates the court, the medical adjudication board, the insuring entities and those concerned with control of loss, knowing for what categories of loss, that is, medical expense, lost earnings, future loss of income, general damages or other categories of loss the awards are intended.

Recommendation: [No. 13]

Jury and board awards shall be rendered by category of loss.

THE INSURANCE SYSTEM

The thrust of the whole problem for the hospitals and physicians is the unavailability of professional liability insurance coverage at a reasonable price.

Several factors were found to have contributed to much restricted markets.

Within the last two years, the insurance industry has suffered an underwriting loss of heretofore unmatched proportions.

In addition, many insurance companies found themselves heavily invested in securities dramatically affected by the severe drop in market values which, while not affecting income or loss, except for those carriers forced to sell at a loss to raise cash, had the affect of materially reducing net worth to the point that the industry was, and still is, required to reduce their premium writings in order to keep the ratio of writings to surplus within acceptable parameters.

Thus, carriers were, and still are, forced to evaluate which of its lines or books of business must be reduced or eliminated to reduce writings and increase the potential for profit.

Obviously, the catastrophic developments in medical malpractice insurance losses resulting from the factors of claim consciousness and the tail exposure explained above made this line of insurance an obvious candidate for elimination from carrier portfolios.

The problem was compounded when, in the latter part of 1974, Argonaut Insurance Company first announced that because of its seriously impaired financial condition, it was withdrawing entirely from the physicians malpractice field and precipitated a publicly aired outcry from the medical profession and insurance regulators.

Although these matters related little to the results on the malpractice business sold in Alaska, the decisions to substantially increase rates or withdraw from the field affected Alaska only because the carriers allowed for no special consideration for possible profitable business in very small market areas.

One of the historically most reliable sources for malpractice insurance has been Lloyds of London which has, for many years, marketed a claims-made form. More recently, American carriers responded to the malpractice insurance problem by switching from an occurrence form to a claims-made form. Unfortunately, little attention was paid by doctors to the policy form until it became a visible issue and the doctors became alarmed at the possibility that, at retirement or discontinuance of practice or discontinuance of the insurance program, they would have a residual exposure not covered by insurance.

The degree to which these fears are justified depends upon the structure of the program provided. For example, under the Lloyds form, three years of discovery time after the last year of coverage was provided at no additional cost. For a while it was possible to procure tail protection for the period beyond three years for additional premiums.

Marsh & McLennan offers a program through Shand, Morahan & Company, Inc., which provides three years of discovery protection after the last year of primary protection for additional premium, but no protection for discoveries after three years..

In some other states, St. Paul Fire & Marine offers a claims-made program which is guaranteed renewable but without a guarantee of a certain rate and guarantees the availability of occurrence form tail protection after the last year of claims-made coverage for an agreed percentage of the then year's rates for the basic coverage.

The confusion over the cost and kind of protection provided led most Alaska physicians to refuse all claims-made coverage until satisfactory protection of late discovered claims and proper pricing was obtained.

Probably the greatest confusion came about in the eyes of the Alaska public when several high risk class doctors proclaimed publicly that they were paying \$36,000 per year for coverage. As a matter of fact, under the Marsh

& McLennan program which was cited as an example, that price was found to include provision for three years of discovery protection which, so long as the practitioner practices and continues to purchase basic primary coverage every year, would not be needed until after the last year of practice, retirement or discontinuance of the insurance program. The one year premium for the basic primary coverage including limits to \$1,000,000 was found to be \$18,000 per year. The detail of this premium is shown on Exhibit 10.

Overall the premiums for malpractice insurance for hospitals and physicians

has not been demonstrated to relate exclusively or even primarily to Alaska's experience. Testimony before the Commission indicated that development of Alaska's malpractice experience indicates a lowering of rates.

Unfortunately, the one admitted carrier writing in Alaska and thus required to file rates, provides occurrence coverage at modest rates but has not written medium or high risk specialties and is taking no new risk.

The other providers of coverage are nonadmitted carriers and thus not bound to any filed rate. The rate schedules used are based more on national statistics which results in exceptionally high rates.

The examination of rates led to two important observations about the Alaskan insurance market.

First, there is now no place, either in a governmental agency or any private carriers where statistics which are specific, reliable and credible are accumulated.

Second, the health care providers in this State are few in number and, thus, even if taken all together are a difficult class over which to distribute risk. Despite that fact, the doctors have continued to procure insurance from many different sources with the result that no carrier had a sufficient book of business to make it economically or actuarially worthwhile to continue their participation in the State.

For example, from available statistics it was generally found that doctors were, in early and mid 1975 procuring their insurance from:

<u>Carrier</u>	<u>Number of Doctors</u>
Continental Insurance	100
Lloyds of London	50
Marsh & McLennan	15
National OB-GYN Group	20
National Internists Group	20
Group Practice Program	50
Voluntarily uninsured	<u>60</u>
Total licensed physicians	315

It was found that currently most nurses and other health care providers are not having problems procuring coverage at a reasonable price. Hospitals, are having difficulty obtaining adequate coverage and quotes on renewals indicate that costs are about to increase dramatically.

The most serious concerns identified by the hospitals and physicians were:

- a) incomplete coverage for the late reported cases;
- b) lack of continuity in the insurance program;
- c) rates not related to Alaska's experience;
- d) no assurance that coverage would be available at any price on a permanent basis.

Health Care Providers' Indemnity Corporation

To bring some constancy to the insurance program, the Commission felt that the only way a group as small as the physicians' group in Alaska could successfully negotiate for coverage would be to act in concert, bringing to bear the bargaining power of all of the malpractice premiums in the State.

Historically, the medical association in this State has been unable to galvanize their membership into a common malpractice program. It, therefore, seems necessary to legislate the programs.

Recommendation: [No. 14]

Create a Health Care Providers Indemnity Corporation, a public corporation, which would be regulated by the Director of Insurance as a domestic property and casualty insurer and which would be a mandatory and exclusive source of minimum limits of medical malpractice insurance for all health care providers for the losses reported within the first three years after occurrence.

The Commission does not feel that at this time it is necessary or proper for the State to be financially involved in the program. Rather, the amount of premium which would flow through the system, if all health care providers are included, and if the rating structure is predictably profitable, should be attractive to many private insurers.

Recommendation: [No. 15]

The corporation may contract with servicing carriers for

administrative and claims services and seek contracts of indemnity from admitted carriers retaining for itself no insurable risk.

Rates

In order for the program to be economically successful and also to carry out the principle that the health care providers should bear their own true costs,

Recommendation: [No. 16]

The rates for the coverages provided by the corporation should be developed based on Alaska's experience and retrospectively adjusted over a four year period such that each category of health care providers would fully pay for all losses and expenses incurred in the programs yielding an appropriate profit to the indemnity carrier.

The physicians testified that the six classification rating system utilized almost universally by carriers in pricing malpractice coverage has greatly exaggerated the difference in exposure for high risk and low risk doctors. They noted that a different rating structure would be more equitable and affordable if it reduced the cost to the high risk physicians even if it required increasing the rates to low risk physicians.

There has been a preference expressed for rating physicians on gross

medical revenues, since, at least theoretically, the gross medical revenues of a physician reflect the degree of complexity and risk in the physician's practice.

Each of the health care providers other than physicians and hospitals have expressed concern that by being included in a mandatory insurance program they will be required to pay higher premiums to fund the bad experience of the more hazardous categories of health care.

The use of the indemnity corporation allows sufficient flexibility in the rating plans which it uses, that any cost distribution which the health care providers prefer and which generates sufficient total revenues, can be implemented.

It has been determined by the Commission, however, that no health care providers category should subsidize any other category; each should be self-rated within their separate fields.

Retroactive Coverage

Throughout the year, 1975, the doctors have been subjected to uncertainty about the coverage and its costs and have incurred intermittent periods when they have been practicing without proper insurance.

When the crisis was at its worst, several surgeons, some anesthesiologists and others continued their practices, either without coverage or without adequate provision for tail protection.

The Commission believes that it is appropriate that provision be made to provide protection to these doctors.

Recommendation: [No. 17]

The corporation provide coverage retroactively to January 1, 1975 with appropriate additional premiums for those health care providers which had no insurance during that period.

Joint Underwriting Association

It is conceivable that no private market will seek to indemnify the corporation. To provide consistency of the program there must be some standby mandatory availability:

Recommendation: [No. 18]

A joint underwriting association should be authorized to be implemented upon a finding by the Director of Insurance that indemnity at a reasonable rate is not available from a private carrier.

A joint underwriting association is a means of spreading potential loss through insurers to classes of insureds other than the class of insureds subject of the primary risk. It serves a useful purpose when, for reasons beyond the control of the carriers, the coverage can be obtained no other way.

The joint underwriting association recommended by the Commission differs from that which was the subject of SB 361 passed by the legislature earlier this year in three particulars:

- a) This joint underwriting association is recommended only as part of a total scheme designed to address both the symptoms and fundamental causes of the problem. This is important. Enactment of a joint underwriting association without making the other fundamental changes only transfers the basic problem; it does not solve it.
- b) By reason of the other changes in law recommended by the Commission, the joint underwriters association would only be indemnifying losses reported within the first three years after occurrence. The joint underwriting association in SB 361 had continuing liability for the tail exposure.
- c) The joint underwriting association in SB 361 was not an exclusive source for malpractice insurance. The joint underwriting association proposed by the Commission would indemnify the mandatory and exclusive corporation insurance program. This difference is significant. Because of the rating structures proposed by the Commission, a relatively good spread of risk can be achieved without unreasonable cost to any health care provider and no on-going loss to the plan.

Where the joint underwriting association is permissive only, the good

risks will be written by the private carriers providing reasonable rates through national underwriting programs and the high rated classifications and poor risks will be forced into the joint underwriting association bringing the rates up for the residual doctors or causing an ongoing loss to the plan or, most likely, both.

The insurers which ought to participate in the joint underwriting association are those which are most benefited by the quality and cost of health care and which can best distribute any costs borne for this program over the widest possible base.

Recommendation: [No. 19]

The joint underwriting association should be composed of all property, casualty and disability insurers and all health care service contractors.

The Commission has given serious consideration to including the unlicensed medical and disability programs of labor unions. It is the opinion of the Commission that these programs are equally capable of sharing in this cost and ought to do so. Because, however, they are unlicensed and, thus, to include them would require the consideration of issues not now before the Commission, it is suggested that the legislature explore the feasibility of their inclusion.

Late Claims Fund

Because of the cutting off of health care provider liability three years after occurrence, the source for recovery on late filed claims must come from a separate fund.

The Commission considered the question of how to fund the fund at great length

There is a potential for exposure to late claims that could result in substantial system expense. This was, after all, the reason most insurance carriers elected not to continue responsible for such exposure. The Commission points out that there is a need for a State guarantee of the fund to cover a claim made which exceeds the fund assets. There may be the further need for State participation if the cost to the health care providers to properly fund the fund becomes unaffordable.

The Commission believes that provision should be made for administrative determination of the actuarial requirements of the fund for each category of health care provider and that the legislature determine the degree to which a governmental guarantee ought to be allowed.

Recommendation: [Ho. 20]

Create a late claims fund which shall be funded by assessments against all health care providers in amounts determined by the

Director of Insurance after public hearing as necessary to actuarially carry all fund liabilities and guaranteed by the State to the extent necessary to cover actuarial deficiencies. There should also be provision for the legislature to reduce the assessment of health care providers upon a finding that the assessment is unaffordable.

Statistics

The existence of a single source for malpractice insurance will necessarily result in many improvements in the statistical, reporting and reserving requirements for this line. Nonetheless,

Recommendation: [No. 21]

Legislation should be enacted which will require the maintenance of separate, specific and detailed statistical information on malpractice claims. Authority should be exercised by the Director of Insurance to more deliberately regulate policy forms and rates for this line.

This information will enable future administration and legislatures and, of course, the health care providers and insurers, to make more informed judgements about the coverage and its costs.

Health Care Providers

Defining health care providers to be included in the proposal is based upon the following considerations:

- a) Since the program is mandatory, some efficient means of enforcement is necessary. Using the licensing agency as a means of assuring compliance with the mandatory insurance provisions was regarded as most appropriate since it coincides with the proposal calling for the licensing boards to more effectively regulate the health care providers.
- b) One of the values of a common source for indemnification of all health care providers is the ability to provide a common defense. There is a significant cost savings if all those who might be involved in a malpractice action would be in the program.
- c) One of the purposes of requiring all insurance for health care providers to be purchased from one source is to make the size of the program large enough to be attractive to the private insurance market. That being so, the most inclusive definition of health care providers should be used.
- d) The substantive and procedural tort reforms will affect recipients and participants in health care delivery in all health care provider categories. The Commission believes it would be unwise legislation to provide for certain rules in medical negligence cases against physicians and different rules

for cases against dentists. Since all health care providers benefit from the changes, all should participate in the insurance mechanisms.

Recommendation: [No. 22]

The proposals of this Commission should inure to the benefit of, and be binding upon all licensed in the State as hospitals, as defined in AS 18.20.130 and including hospitals operated by State and political subdivisions, chiropractors, dental hygienists, physicians, osteopaths, chiropedists, nurses, opticians, pharmacists, and physical therapists, dentists, optometrists, psychologists, and pediatricists.

MEDICAL PRACTICE

A most significant impact upon the total cost of the system can be achieved by the health care providers through self-discipline and self-policing. Several specific problems were detected which make it difficult to properly achieve these results within the health care professions.

Informed Consent

Cases have been brought elsewhere against doctors, not because they performed a procedure negligently, but because they performed it without the permission of the patient, or allegedly obtained consent without properly explaining the consequences of the procedure to the patient.

Physicians frequently find it necessary to perform surgery or other procedures under circumstances where an informed consent cannot be obtained or where, because of psychological or emotional considerations it would be ill advised to be overly graphic in informing the patient of all the consequences of a needed procedure.

Recommendation: [No. 23]

There should be a legislatively prescribed procedure for informing the patient of the consequences of a procedure and obtaining the consent to perform it and also setting forth the conditions pursuant to which consent is implied or not required.

Licensing Board Authority

Discipline must be the joint responsibility of the profession and the State agency regulating the profession.

Unfortunately, under Alaska law, most medical regulatory agencies have only the authority to grant or revoke a license. Frequently, practitioners have been regarded as unable to practice in the broadest authority of their license but the agency has been reluctant to revoke the license except in the most severe circumstances.

The Commission believes that intermediate sanctions should be authorized so that discipline can be fairly administered for the protection of the public without necessary detriment to the livelihood of the practitioner.

Recommendation: [No. 24]

The appropriate licensing boards should be authorized to render disciplinary sanctions against health care providers other than license suspension. The boards should be able to reprimand, censure, place on probation, restrict practice by time, specialty, procedure or facility or to require continuing education or retraining.

Defamation Immunity

In order for the disciplinary function of the State agency, the professional association or the hospital staff committees to be effective, other professionals must be able to bring matters to the attention of the appropriate body

without fear of recrimination.

At this time, medical practitioners are reluctant to divulge information concerning observed negligence or misconduct for fear the practitioner involved will bring an action for defamation.

In addition, more information is available from health care providers than is currently made available to the licensing boards.

Recommendation: [No. 25]

The appropriate licensing board should have authority to require more relevant and more frequent reports on health care practices by and from its licensees. Persons reporting should have immunity from defamation actions based on reports made to licensing boards to officially constituted service committees of hospitals and professional health care organizations.

Funding

In order for the licensing boards to be effective, sufficient administrative and investigative staff must be employed.

Recommendation: [No. 26]

The legislature appropriate such additional funds as are needed to properly staff the health care licensing boards with investigative and administrative personnel.

Ultimately, reduced frequency of loss from negligent conduct is achieved only if the attitude of the persons involved is tuned to an awareness of the need for careful conduct.

There are available professional loss control consultants that specialize in the control of hospital malpractice losses.

Recommendation: [No. 27]

Provision should be made for more effective loss control by all health care providers but with specific attention to identified problem areas.

III. CONCLUSION

The Commission is convinced that this package of proposals when taken together is one of the most complete, feasible and marketable proposals to be considered in any state. It does no violence to the legitimate rights of persons injured as a result of negligent conduct. It removes some inequities.

It costs nothing of the State and, in fact, may result in savings in judicial expenditures, unless the legislature should elect to partially fund the late claims fund in which case there would be expense to the State to that extent. It preserves the role of the free enterprise system as a primary provider of protection.

This set of recommendations answers all of the serious legitimate objections to the present system raised by insurers. It meets the objective of the Commission by making the exposures controllable and thus actuarially predictable and controls ultimate total cost.

The Commission was made aware of the fact that the proposals of other states have not brought immediate insurance availability.

Changes to the tort system which seriously impair due process or a person's right to full recovery have been challenged as unconstitutional and insurance carriers have adopted a "wait and see" attitude.

As the Commission worked on developing a solution, contact was made with carriers to determine if they would provide the indemnity. Attached as Exhibit 10 is a letter from one carrier which is giving serious consideration

to providing the coverage. When the program becomes law, negotiations will be open to all carriers and brokers to submit proposals. The attached letter, however, demonstrates the practical feasibility of these recommendations.

The Commission finally recommends that to implement these proposals the following steps be taken:

1. The Supreme Court of the State of Alaska consider enacting rules implementing the recommendation to establish the expert medical panel.
2. The legislature enact the legislative proposal which this Commission will provide and which implements all of these recommendations.
3. The legislature, by Concurrent Resolution, place on the ballot for the general election in 1976 the recommended constitutional amendment.

GLOSSARY

Claims-made form

A policy of insurance that covers only those claims which are reported to the insurer during the policy period and which arise out of incidents occurring after the issuance of the first policy with that insurer. Claims arising out of incidents occurring during the policy period but reported after expiration are not covered.

Comparative Negligence

A rule of law which requires reduction of an award to an insured plaintiff against a negligent party if the plaintiff is also negligent in proportion to the degree of plaintiff's negligence.

Contributory Negligence

A rule of law which requires denial of an award to an injured plaintiff against a negligent party if the plaintiff is negligent to any degree.

Discovery

Procedures instituted by the parties to litigation after filing an action and prior to trial of an information gathering nature which enables the parties to elicit and evaluate all testimony and data that might become evidence in the trial.

Tail

The period of exposure to liability which exists between the date of an incident which could give rise to liability and the last date on which the fact of liability can be adjudged.

EXHIBITS

1 IN THE SENATE

BY THE FREE CONFERENCE COMMITTEE

2 FREE CONFERENCE CS FOR HOUSE CS FOR SENATE BILL NO. 361

3 IN THE LEGISLATURE OF THE STATE OF ALASKA

4 NINTH LEGISLATURE - FIRST SESSION

5 A BILL

6 For an Act entitled: "An Act concerning health care liability insurance; and
7 providing for an effective date.

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

9 * Section 1. AS 21 is amended by adding a new chapter to read:

10 CHAPTER 67. HEALTH CARE LIABILITY UNDERWRITING ASSOCIATION.

11 Sec. 21.67.010. JOINT UNDERWRITING ASSOCIATION. The director of
12 the division of insurance shall establish by regulation a joint under-
13 writing association to provide health care liability insurance to health
14 care providers in the state on a self-supporting basis. All insurers who
15 are authorized to write and are engaged in writing casualty or disability
16 insurance in the state on a direct basis, and all insurers who are
17 authorized to issue and are issuing subscriber's contracts in the state
18 on a direct basis, shall be members, (except that any disability insurer
19 shall be exempted by the director of the division of insurance upon a
20 showing that such insurer is prohibited by charter or by any law of the
21 United States or any state from writing casualty insurance) Membership
22 in the association is a condition of transacting insurance business in
23 the state.

24 Sec. 21.67.020. PARTICIPATION IN ASSOCIATION, DIRECTORS. (a)

25 Each member participates in the writing of policies, expenses, profits
26 and losses of the association in the proportion of the net direct premi-
27 ums written the preceding calendar year in the state by each member,
28 excluding the premiums attributable to the operation of the association,
29 to the aggregate net direct premiums written in the state by all members

1 of the association in the preceding calendar year. Each member's parti-
2 cipation in the association is determined annually on the basis of the
3 annual statements filed by the member with the division of insurance.

4 (b) The association shall be governed by a board of three
5 directors, who are elected by cumulative voting of the members of the
6 association; the votes are weighted according to each member's partici-
7 pation the year of the election. The directors serve terms of two
8 years. The directors on the first board shall be elected at a meeting
9 of members at a time and place designated by the director of insurance.

10 Sec. 21.67.030. POWERS AND DUTIES OF ASSOCIATION. The association
11 may

12 (1) issue or authorize the issuance of policies of insurance
13 to applicants;

14 (2) underwrite the insurance policies issued and adjust and
15 pay losses on the policies;

16 (3) accept and cede reinsurance;

17 (4) appoint, with the permission of the director of insurance,
18 service companies to perform its duties under this chapter; and

19 (5) adopt regulations, subject to approval by the director of
20 insurance, necessary for carrying out the provisions of this chapter.

21 Sec. 21.67.040. OPERATING PLAN. (a) The association shall
22 develop an operating plan to carry out the provisions of this chapter,
23 which is subject to the approval of the director of insurance. In
24 developing the plan the association shall receive input from health care
25 providers in the state and from representatives of the public.

26 (b) The operating plan shall provide for fair, prompt, and eco-
27 nomically self-supporting health care liability insurance and shall
28 include

29 (1) a preliminary assessment to all members for the expenses

1 necessary to begin operation;

2 (2) underwriting standards;

3 (3) appointment of servicing carriers;

4 (4) rating plans and classifications established on an actu-
5 arily sound basis and calculated to be self supporting;

6 (5) other provisions found necessary by the association.

7 (c) The association shall submit the operating plan to the director
8 of insurance for approval within 60 days after the director of insurance
9 establishes the association under sec. 10 of this chapter.

10 (d) The operating plan may be revised by an affirmative vote of a
11 majority of the directors and concurrence of the director of insurance.

12 Sec. 21.67.050. PROFITS AND DEFICITS. (a) Profits made by the
13 association may be added to the reserves of the association.

14 (b) A deficit sustained by the association in any one year shall
15 be recouped by rate increases applicable prospectively or offset against
16 the tax on total direct premiums specified in AS 21.09.210 if the offset
17 is approved by the director of insurance after determining that it is in
18 the best interest of the state and the persons intended to be benefited
19 by this chapter.

20 Sec. 21.67.060. ANNUAL STATEMENTS. The association shall file an
21 annual statement to the director of insurance before March 16 reporting
22 its operations of the preceding year.

23 Sec. 21.67.070. PERSONS COVERED. (a) Any health care provider
24 licensed by the appropriate licensing agency of the state may apply to
25 the association for health care liability insurance.

26 (b) If the applicant meets the underwriting standards of the asso-
27 ciation as provided in the operating plan and there is no unpaid, uncon-
28 tested premium due from the applicant for prior insurance, the associa-
29 tion on receipt of the premium shall issue or cause to be issued a

1 policy of health care liability insurance for a term of one year.

2 (c) In no event may the association deny insurance to a health
3 care provider without the concurrence of the director of the division of
4 insurance.

5 Sec. 21.67.080. HEALTH CARE LIABILITY POLICIES. (a) The associ-
6 ation shall offer policies on both a claims made and occurrence basis.

7 (b) Each policy issued by the association shall provide minimum
8 coverage to the insured in an amount of not less than \$100,000 for each
9 occurrence and \$300,000 for all occurrences in any one policy year for
10 the protection of persons who are legally entitled to recover damages
11 from the insured for errors, omissions or neglect in the performance of
12 the insured's professional services. The association may establish
13 minimum levels of coverage higher than these limits for professional
14 practice involving a high degree of risk.

15 (c) No policy issued on behalf of the association may be cancelled
16 during the term of coverage without the concurrence of the director of
17 the division of insurance.

18 Sec. 21.67.090. APPEALS AND JUDICIAL REVIEW. (a) An applicant to
19 the association, an insured under this chapter, or a member may appeal
20 to the director of insurance within 30 days of any ruling, decision, or
21 action by or on behalf of the association.

22 (b) All orders of the director of insurance under this chapter are
23 subject to judicial review.

24 Sec. 21.67.100. DEFINITIONS. In this chapter

25 (1) "association" means the underwriting group established
26 under the provisions of this chapter;

27 (2) "casualty insurance" means casualty insurance as defined
28 in AS 21.12.070;

29 (3) "director" means a member of the board of directors of

1 the association;

2 (4) "director of insurance" means the director of the division
3 of insurance in the Department of Commerce;

4 (5) "disability insurance" means disability insurance as
5 defined in AS 21.12.050;

6 (6) "health care liability insurance" means insurance against
7 the legal liability of the insured for loss, damage, or expense incident
8 to a claim arising out of the death or injury of a person as a result of
9 negligence in rendering professional service by a health care provider;

10 (7) "health care provider" means a physician licensed under
11 AS 08.64, a nurse licensed under AS 08.68, an institution licensed under
12 AS 18.20, and a dentist licensed under AS 08.36;

13 (8) "net direct premiums" means gross direct premiums written
14 on casualty and disability insurance less return premiums or the unused
15 or unabsorbed portions of premium deposits; .

16 (9) "subscriber's contract" means subscriber's contract as
17 defined in AS 21.87.330(6).

18 * Sec. 2. This Act expires on April 1, 1977.

19 * Sec. 3. This Act takes effect immediately in accordance with AS 01.10.-
20 070(c).

* July 2, 1975

The Honorable Chancy Croft
President of the Senate
Alaska State Legislature
Juneau, Alaska 99811

Dear Mr. President:

Although I am convinced there is a need to rewrite the Alaska Statutes dealing with medical malpractice insurance, I must veto Free Conference Committee Substitute for House Committee Substitute for Senate Bill 361, "An Act relating to health care liability insurance". In establishing a new method, wherein related medical agents and organizations may be protected in their business through insurance programs, the bill has, in my opinion and in the opinion of many others, fallen far short of yielding an adequate solution to the problem.

Only recently has the extensive outcry from members of the general and professional public been raised in opposition to the bill. In fact, there has been virtually no support of the bill from those most directly affected by its enactment. Dentists, insurance companies and hospitals have all voiced strong opposition to the bill for a number of reasons and some doctors have evidenced misgivings with the bill. Physicians do not consider the bill to be a solution to their problems and yet, they are vitally interested in corrective legislation.

As the bill was hastily passed by the Legislature (in fact, it had 15 separate legislative actions within a period of less than 36 hours), public input to the legislation was limited.

First, and most critical, is the last minute inclusion of the health care service organizations like Blue Cross as a participant in the joint underwriting association created by the legislation. The coverage to be provided by the joint underwriting association is casualty insurance; Blue Cross cannot write or reinsure this type of insurance because of its charter and because of the fact its home state laws do not permit it to do so. The legislation further allows a disability insurer in a similar situation to be exempt from participation. However, this bill appears to be worded in a way to deny such exemption to Blue Cross. An official of Blue Cross has publicly stated that he seriously questions the ability of Blue Cross to continue operation in Alaska should the bill become law. Currently, Blue Cross provides health coverage for about 60,000 residents of Alaska. If Blue Cross did remain in Alaska, it would have to operate in violation of its charter and at substantially increased costs to its subscribers.

Second, when health maintenance organizations are formed, they must do so under the same chapter under which Blue Cross operates. Should this bill become law, it would act as a severe deterrent to the establishment of such health maintenance organizations.

Third, the legislation provides an expiration date of April 1, 1977. This section causes considerable concern due to the fact that one of the major difficulties with such insurance has been delayed discovery of claims, often several years after policies have been written. In fact, I understand that most claims would not be discovered until long after April 1, 1977.

Fourth, there is a legitimate concern that the limits of liability required by the legislation may be insufficient as primary coverage to make excess coverage from other sources available to the users of the joint underwriting association. This could, in effect, place a \$100,000 limit of recovery on medical malpractice cases.

Fifth, the legislation requires that rating plans and classifications be established on an actuarially sound basis and that they be self supporting. Since Alaska has a relatively small health care population, it has an insufficient number of policies over which it may spread the expenses of the proposed joint underwriting association. Hence, it appears probable that the insurance rates would soar.

Because of these major considerations and other attendant minor considerations, I will, within 15 days, be appointing a committee to develop a thoroughly comprehensive package of legislation to be introduced during the next session.

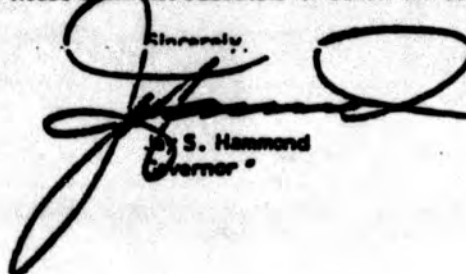
As President of the Senate, you are invited to designate one senator for appointment to the legislation drafting committee.

It is evident that the problem cannot be solved by a single bill. In Nevada, a highly workable program was developed but it required separate pieces of legislation. In California, an entire Special Session of the legislature was devoted to such insurance problems. Through this committee, I intend to appoint a team of qualified professionals as well as concerned consumers to solicit input from all those affected by such legislation. The committee's main charge will be to write a practical, workable package of health care liability insurance and deliver it to me by November 1, 1975. The committee's executive secretary will be supplied by the Commissioner of Commerce, who is preparing basic background information packages for the committee members (including copies of legislation from other states). Other staff members from the Department of Law and the Department of Health and Social Services will also be available.

I sincerely hope that there will be no need to call a Special Session of the Legislature. However, should a crisis occur, that is, should the general public be seriously jeopardized through cancellation of insurance, a strike, or any similar calamity, I will strongly consider calling the Legislature into session. To further preclude such an unwanted act, I have urged all those involved, including doctors, hospitals, insurance companies, etc., to work closely, and with as much advance notice as they are afforded, in preventing any changes in insurance coverages that would adversely affect the public and the insured, during this interim period.

Therefore, for the reasons discussed, I have vetoed Free Conference Committee Substitute for House Committee Substitute for Senate Bill 351.

Sincerely,



Jay S. Hammond
Governor

SCHEDULE OF MEETINGS

July 28, 1975	Boney Court Building, Anchorage
July 29, 1975	Boney Court Building, Anchorage
July 30, 1975	Boney Court Building, Anchorage
August 5, 1975	Boney Court Building, Anchorage
August 6, 1975	Boney Court Building, Anchorage
August 7, 1975	Boney Court Building, Anchorage
August 8, 1975	Boney Court Building, Anchorage
August 14, 1975	Boney Court Building, Anchorage
August 15, 1975	Borough Assembly Room, Anchorage
August 16, 1975	Boney Court Building, Anchorage
August 17, 1975	Boney Court Building, Anchorage
August 25, 1975	State Office Building, Juneau
August 26, 1975	State Office Building, Juneau
August 27, 1975	State Office Building, Juneau
September 3, 1975	Loussac Library, Anchorage
September 4, 1975	Transportation Hearing Room, Anchorage
September 5, 1975	Providence Hospital, Anchorage
September 16, 1975	Borough Assembly Room, Anchorage
September 17, 1975	Borough Assembly Room, Anchorage
September 18, 1975	Borough Assembly Room, Anchorage
September 23, 1975	Boney Court Building, Anchorage
September 24, 1975	Boney Court Building, Anchorage
September 25, 1975	Boney Court Building, Anchorage
September 30, 1975	Baranof Hotel, Juneau

FUTURE MEETINGS

October 17, 1975	Boney Court Building, Anchorage
October 18, 1975	Boney Court Building, Anchorage
October 19, 1975	Boney Court Building, Anchorage

LIST OF WITNESSES

Susan Burke	Alaska Court System Representative
Dick Block	Consultant - Various Presentations
Don Koch	Alaska Division of Insurance
N. E. Segelhorst	Insurance Agent/Broker
Don Coates	Ken C. Johnson, Inc.
Jamie Love	Insurance Agent/Broker
Ken Atkinson	Dawson & Co. Inc.
Bob Nestel	Commission Member
Martin Tirador	Presentation on Claims Data
Dr. R. Wilson	Commission Member
Bob Libbey	Presentation on Attorney's Role
Dr. Green	Commission Member
Dr. Bruce Wilson	Presentation on Comp. Health Care
Dr. George Ryneer	Commission Member
Dr. Chou	Presentation on Health Care Delivery Sys.
Dr. Shafel	Commission Member
Dr. Behym	Present. on Inflation in Medicine
Dr. Von Hippel	Commission Member
Sister Josephine Patty	Present. on Statute of Limitations
Brian Saylor	Physician
Dr. Beal	Physician - Radiation Therapy
Dr. Virginia Wright	Physician
K. C. Chu	Physician - Anesthesiologist
Keith Kun Dahl	Physician
Dexter Mapel	Physician
Mike Thomas	Physician - Open Heart Surgeon
Edward Lararek	Administrator - Kodiak Island Hospital
Richard L. Stites	Health Affairs Advisor
Jane Jones	Physician - Anesthesiologist
William Walters	Physician - Psychiatrist
Edgar Paul Boyco	Restaurant Owner
Grant Hubbard	Prospective Medical Student
James Delaney	Insurance Agent/Broker
Arne Werchick	March & McLennan
	Attorney
	Representing American Insurance Assoc.:
	Insurance Services Offices Rep.
	Woodside East
	Attorney
	Insurance Broker, Shann-Morahan
	Attorney
	Calif. Firm of Werchick & Werchick

Susan Overby
Tony McFarley
Ashford B. Kelly
Ava McGee
Donna Jean Lewis
Carolyn Vic
Mr. Clare Thompson
Joe Josephson ✓
Richard Garnett
Fran Olmer
Dr. Southerland

Avrum Gross
Art Peterson
Art Snowden
Dr. Gary Hedges
Bernard P. Kelly

Attorney
Attorney
Governors Office
Dentist
Alaska Dental Society President
Attorney General
Assistant Attorney General
Alaska Court System
Physician - Surgeon
Attorney

LIST OF MATERIAL REVIEWED

**HEW REPORT (Report of the secretary's commission on
Medical Malpractice)**

LEGISLATION FROM

Arizona
California
Florida
Indiana
Massachusetts
Michigan
Nevada
New York
Ohio
Oregon
Texas

LEGISLATIVE PROPOSALS FROM

Alaska
Arne Werchick
St. Paul Insurance Companies
Alaska State Medical Association
National Association of Independent Insurers

POSITION PAPERS FROM

American Mutual Insurance Alliance
Defense Research Institute
Insurance Backgrounder - State Farm Insurance Companies
Insurance Information Institute
Insurance Services Office
Ohio Director of Insurance - White Paper
Morahan
Underwriters Report

RESEARCH BRIEFS

American Hospital Association
Council of State Governments
Medical Adversity Insurance - No Fault
Data Of Medical Economics
Dexter Mapel Presentation

LEGISLATIVE CRITIQUES

University of California - San Francisco
Medical Liability Commission (Chicago)
American Insurance Association Comparison Charts

SPECIAL EDITIONS OF

Trial Magazine February - March 1970
Trail Magazine May - June 1975
Malpractice In Focus, An American Medical Association
Source Document
U.S. News And World Report - June 16, 1975

ARTICLES AND NEWS CLIPPINGS FROM

Anchorage Daily News
Anchorage Daily Times
Fairbanks Daily News-Miner
Juneau Southeast Alaska Empire
Business Insurance
Underwriters Report
The Weekly Underwriter
Insurance Week
The Wall Street Journal
Readers Digest
Journal of American Insurance
International Insurance Monitor
Boston Globe
New York Post
San Francisco Chronicle
Christian Science Monitor

REPORT ON ALASKA MEDICAL MALPRACTICE SITUATION -
January '75, Alaska Division of Insurance

INSURANCE POLICY FORMS

Shann Morahan - Claims Made
Lloyds of London - Claims Made
Standard - Occurrence

STATE OF ALASKA

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

OFFICE OF THE COMMISSIONER

JAY S. HAMMOND
GOVERNOR

POUCH B - JUNEAU 0811

July 30, 1975

The Honorable Jay S. Hammond
Governor
State of Alaska
Pouch A
Juneau, Alaska 99811

Dear Governor Hammond:

On this day, the Commission on Medical Malpractice Insurance which you appointed to study the current availability of medical malpractice insurance for the doctors and hospitals in this State has completed three full days of public hearings in the State Court House in Anchorage. Because the Commission is of the view that the situation is both vitally important for health care in this State and because certain doctors have an urgent need for an immediate solution, this interim report is indicated.

The Commission has heard testimony from the leading physicians, surgeons, medical specialists in this State, insurance brokers, insurance company executives and attorneys. All the members of the Commission have all contributed valuable information. From the testimony taken so far, the following, preliminary conclusions can be stated:

1. There is a real and serious question of the actual availability of adequate insurance coverage for doctors in this State.
 - a. There are essentially four sources for this coverage:
 - i. Continental Insurance Company
 - ii. Shand, Morahan Underwriters
 - iii. Lloyds of London
 - iv. There are limited national specialities association policies which are decreasing in numbers.

The Honorable
Jay S. Hammond

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July 30, 1975

- b.
 - i. Continental Insurance will not accept new risks.
 - ii. Shand, Morahan provides only a claim made form.
 - iii. Lloyds has indicated its intention of withdrawing completely from the market.
 - iv. A search of brokers has turned up no additional potential market sources.
 - c. The claims made form provides a type of coverage which may be too restrictive to properly protect the doctors over the full course of their professional career.
2. The exposures to liability are less susceptible to predictable measurement.
- a. Society may be increasingly litigation conscious.
 - b. Medical procedures are far more complex and involve inherent risks.
 - c. Many types of treatment, result in detrimental effects apparent only many years after the treatment.
 - d. The current law presents questions as to the definite cutoff of liability regarding time.
3. The matter is extremely complex and does not lend itself to an easy solution.
- a. Further statistical information is required: Statistics as to number, amount and character of claims filed against doctors must be developed.
 - b. Comparison of insurance rates:
 - To claims
 - To other states
 - To other professions
 - To inflationmust be studied.
- Actual evaluation of cost savings from proposed law changes must be studied.
- c. It is expected that whatever permanent solution is proposed will require legislation. There are serious questions of constitutionality and public policy that must be considered as to each presently discussed possible solution.
 - d. Much of the information necessary to properly evaluate rates, underwriting considerations and claim costs must come from out of state.

The Honorable
Jay S. Hammond

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July 30, 1975

4. The problem has three aspects:
 - a. The threat of unavailability of insurance for doctors is immediate in that certain doctor's coverage with Lloyds expires within a few days.
 - b. The matter must be addressed with the hope of finding a long range solution that will allow insurance carriers to provide a continuing and stable market.
 - c. The public may be adversely impacted by the resultant curtailment of medical services and increased costs.
5. The Commission concluded these first sessions with a resolve to continue studying the matter on an urgency basis. An agenda which includes arriving at a permanent solution has been agreed upon, the Commission will meet next Tuesday, Wednesday and Thursday in Anchorage.
6. In view of the progress made by this Commission, its members have unanimously urged all interested parties to take no precipitous action which would aggravate the already critical nature of the matter so only as this Commission continues its conscientious effort towards a permanent solution.
7. The Commission fully appreciates and understands that any delay in finding a solution causes an undue and very large burden on the practitioners and the public. As to the practitioners who continue normal and good medical service to the public we feel that the public should fully understand the grave risk many of the practitioners run in the current insurance - or lack of it - environment. The public and the government should empathize with this act of genuine public service displayed by practitioners who continue virtually unprotected in a manner deemed appropriate and desirable by all.

Sincerely,


Larghorne A. Motley
Commissioner

cc: Commission members

MARSH & McLENNAN

August 12, 1975

TO WHOM IT MAY CONCERN, GOVERNOR'S TASK FORCE ON MEDICAL MALPRACTICE
INSURANCE AND ALASKA STATE MEDICAL ASSOCIATION

Gentlemen:

Marsh & Mc Lennan, Inc. of Alaska acting as Broker of Record for the
Alaska State Medical Association and as administrator in Alaska of
Shand, Morahan & Co. - Mutual Fire, Marine & Inland Insurance Company's
Medical Malpractice Program agree to the following:

1. That the Shand, Morahan & Co. Program will provide the
as follows:
 - a. On new policies issued in the Shand, Morahan & Co.
Program where the physician has previously been
insured with Lloyds of London (regardless of syndicate),
we will contractually guarantee that at the end of the
Lloyds discovery period the Mutual Fire contract will be
endorsed to cover incidents which may have occurred
during the period the London contract was in force but
had not been reported at the end of the Lloyds discovery
period. This letter will serve as such contract guarantee
as the actual endorsement to the Mutual Fire contract will
not be added until the Lloyds discovery period ends.
2. We will agree that we will not cancel contracts put into force
except:
 - a. non payment of premium
 - b. for discovery by the carrier that material statements
in the application are false or that during the term of
the policy there has been a change in medical specialty
from that designated by the physician on his application
or physician has been subject to disciplinary proceedings,
committed or treated as provided in Question 18 of the
application.
3. We will agree to continue underwriting and providing as
previously outlined to anniversary date of original agreement
of program; i.e. April 1, 1976, assuming that Marsh & Mc Lennan,
Inc. of Alaska is maintained as Broker for ASMA until that date,
and providing the ASMA takes no affirmative action to misrepresent
the terms and conditions of the program and the policies can be
issued.

MARSH & MCLENNAN

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4. All persons taking this policy must agree to a minimum earned premium on each policy issued of 10% of the annual premium if cancelled by the insured.

MARSH & MCLENNAN, INC. OF ALASKA


By: Dexter M. Mapel
Account Executive


By: R. L. Snitil
Assistant Vice President-Manager

On this 12th of August, 1975, before me, the undersigned, a Notary Public in and for the State of Alaska, duly commissioned and sworn, personally appeared Dexter M. Mapel and R. L. Snitil to be representatives of Marsh & McLennan, Inc. of Alaska.


Notary Public in and for State of Alaska

My Commission Expires
September 13, 1976

MEDICAL MALPRACTICE INSURANCE COMMISSION

August 8, 1975

Jay Hammond
Governor
State Capitol Building
Juneau, AK 99801

Dear Governor Hammond:

The Medical Malpractice Insurance Commission has spent over 45 hours in deliberations, hearing approximately 40 persons testify, received over 90 proposals from the general public, interested local members of the medical, insurance and legal professions and experts invited from other states.

The Commission believes that the magnitude of the long term problem precludes any acceptable comprehensive solution at this stage of our proceedings. Nonetheless, the Commission well recognizes the immediacy of the problem in view of the sharply curtailed health care in Alaskan communities and its attendant long range implications on future availability of medical care to Alaskans. Thus, through the efforts of interested parties, Commission members and the specific insurance brokers and companies involved, an improved insurance program has been made available to the majority of the doctors in the State. The modifications, agreed to by the involved broker, were among the specific items relayed to the Commission as being of most serious concern to the doctors. Specifically, the broker for the Alaska State Medical Association Group Medical Malpractice Insurance Program has agreed to confirm, subject to the approval of the underwriter, Shand, Morahan & Co., that policies issued pursuant to such program will not be cancelled, that they will guarantee the availability of retroactive protection upon expiration of the three-year term protection on Lloyds of London policies provided the doctors had continuous Lloyds of London protection prior to taking the Shand, Morahan & Co. Program and agreed to continuity of the Program through April 1, 1976, provided Marsh & McLennan remains broker of record for the Association. Final approval from Shand, Morahan & Co. is expected prior to August 13, 1975.

The Commission, by unanimous vote of the members present, endorsed the program as a first and interim step, even though

Governor Jay Hammond

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August 8, 1975

the Commission recognizes that this Program does not fully remove the risks or problems faced by all concerned parties and will continue attempts to close gaps in coverage of this interim system.

It is hoped that all involved will see this as a positive step and that the physicians will return to their practices. Meanwhile, the Commission pledges to work toward a system providing a suitable climate for efficient, high-quality medical care at less than prohibited cost.

The Commission plans to meet next week to address specific solutions.

Sincerely,

Langhorne A. Motley, Chairman
MEDICAL MALPRACTICE INSURANCE COMMISSION

AM:kek

Malpractice cases filed in Alaska

(By 1973 Anchorage Daily News)

DATE	TYPE OF PRACTICE	ALLEGED COMPLAINT	REPORTED SETTLEMENT
1957	Internal medicine	Error in pharmacy prescription.	\$2,500, out of court
1957	Surgery	and complications after surgery. Settlement for patient. Case refiled in 1960 with new settlement for patient.	\$410,000, out of court
1958	Surgery	Hip pin punctured bladder.	\$100,000+, out of court
1959	Neurosurgery	Complication following angiogram (a process of injecting dye into blood vessels to show on X-Rays).	\$30,000, out of court
1959	Surgery	Infection following surgery.	\$100,000, out of court
1959	Ob/gyn	Complaint following hysterectomy.	In favor of the doctor..
1959	Surgery	Complications following surgery on hip. Hospital, doctor were sued for loss of consortium (sexual relations).	\$100,000+, out of court.
1961	Surgery	Pin driven through hip socket into abdomen, damaged pin left in body. Jury verdict for doctor. Case appealed to Alaska Court of Appeals and court against doctor.	\$30,000, jury trial; case appealed
1962	Ob/gyn	Complications after birth of twins.	\$1,000, out of court.
1962	Orthopedic surgery	Complaints after surgery.	\$3,500, out of court
1963	General practice	Excessive dose of antibiotics.	Out of court, award to patient
1963	Surgery	Complications after thyroidectomy. Case heard by judge who found doctor not liable. Appealed to Supreme Court and sent back to lower court where it was decided against doctor.	\$60,000, before a judge
1964	General practice	Bridgework destroyed during anesthesia.	\$1050, out of court
1965	General practice	Patient burned during heat therapy.	\$20,000, jury trial
1965	General practice	Death during surgery for ulcer.	\$40,000, out of court
1966	Orthopedic surgery	Improper healing of fractured hand and arm. Settled out of court, refiled in 1971, dismissed.	In favor of the doctor, out of court
1966	Orthopedic surgery	Hand crippled after surgery.	\$7,000, out of court
1966	Surgery	Complications following Cesarean section.	Dismissed when patient's attorney did not appear.

1967	Neurosurgeon	Death in 1965. Patient entered federal hospital complaining of headache, hypertension. Heard by judge in federal court. Decision: August, 1972.	\$2,000, paid by federal government; heard before judge.
1967	Orthopedic surgery	Death. Patient injured in accident; died 17 days after admitted to hospital.	In favor of the doctor, out of court
1967	Internal medicine	Failure to diagnose and treat cancer.	Dismissed in 1959 when patient's attorneys withdrew.
1967	Internal medicine	Loss of leg.	\$165,000, jury trial
1967	Ob/gyn	One-day old baby contracted spinal meningitis. Three-week jury trial.	For the doctor, jury trial.
1968	Surgery	Injuries during surgery.	Out of court
1968	Orthopedic surgery	Hand crippled after surgery for broken wrist.	Dismissed when patient failed to return to Alaska to post bond
1968	Surgery	Dislocated ankle.	In favor of the doctor
1970	Pediatrics	Premature baby born 1968. Case filed in 1970. Jury trial in 1972 declared doctor not liable. Out of state parents appealed case to Supreme Court.	Jury verdict for the doctor, appealed to Alaska Supreme Court, pending.
1970	Ob/gyn	Bladder punctured during hysterectomy	\$20,000, out of court
1970	Pediatrics	Suit filed against doctor's estate.	Out of court settlement
1970	General medicine	Misdiagnosis caused patient to sell business, leave state.	\$7,000, out of court
1970	Oral surgery	Death. Patient died during anesthesia for oral surgery.	\$100,000, out of court
1970	General medicine	Doctor mistakenly reported venereal disease.	In favor of the doctor, out of court
1971	Ob/gyn	Patient still pregnant after legal abortion.	\$3,000, out of court
1971	Orthopedic surgery	Complaints after surgery.	No settlement; patient left state
1971	General medicine	Death. Patient died after inhaling polyurethane. Settlement award split among doctor, medical laboratory and paint manufacturing company.	\$150,000, before a judge
1972	Surgery	Fracture of cervical spine; paral. sis. No suit filed.	\$476,000
1972	General medicine	Failure to follow patient progress after administration of drug.	\$14,000
1973	Surgery	Wife conceived after husband's vasectomy; surgery performed in 1970.	\$7,500, out of court
1974	Oral surgery	Damage to facial nerve.	\$10,000
1974	Orthopedic surgery	Complaints following surgery for varicose veins.	"Nominal," out of court
1974	Physician	Umbilical hernia.	\$100,000, out of court

PENDING SUITS IN ALASKA

Orthopedic surgery: 1
Ob/gyn: 7
Surgery: 5 (two deaths)
Radio/gy: 1

Pathology: 1 (one death)
General medicine: 4
Anesthesiology: 1
Hospitals: 3

Malpractice case list expanded

DATE	TYPE OF PRACTICE	ALLEGED COMPLAINT	REPORTED SETTLEMENT
1957	surgeon	sponge left in patient	\$100,000 out of court
1958	psychiatrist	unknown	unknown
1960	surgeon	surgery performed on wrong rib; more surgery required	out of court
1961	surgeon	doctor did not cure patient	attorney cannot remember settlement out of court
1961	orthopedic surgeon	hip pin installed negligently	? out of court
1962	dental	plaintiff's arm broken during dental treatment	? out of court
1962	surgeon	patient fell out of hospital bed	"very small" out of court
1962	general practitioner	negligent diagnosis	about \$20,000 out of court
1962	surgeon	injuries during anesthesia	\$20,000
1962	surgeon	death, surgery conducted carelessly.	? out of court
1962	surgeon	Baby stillborn	? out of court
1963	physician	negligent treatment	settlement for the doctor out of court
1963	dental	five weeks of pain and suffering after dental treatment	"very small" out of court
1964	physician	complications during local anesthesia	\$100,000
1964	oral surgery	patient died in dental chair	\$70,000 out of court
1965	surgeon	negligence	\$3,545 jury trial
1966	radiology	injury from excess radiation	\$80,000
1967	obstetrics	death during childbirth	doctor's estate sued "nominal"
1969	surgeon	performed surgery without patient's consent	"small" out of court
1970	surgeon	wife conceived after husband's vasectomy	\$750 out of court
1971	surgeon	death during tracheotomy	\$80,000 out of court
1971	neurosurgeon	negligent examination, follow-up	\$300,000 jury trial
1972	gynecologist	Negligent administration of an injection.	\$6,000 out of court
1971	surgeon	Death during anesthesia	\$25,000 out of court
1971	physician	Patient died in jail	\$7,500

COMPUTATION OF PREMIUM

MARSH & McLENNAN PROGRAM

ASSUMING A HIGHEST RATE CLASS PHYSICIAN TERMINATES PRACTICE

Claims made coverage primary limit 200/600 highest rating classification	\$12,080.
Excess coverage to 1,000,000 @ 50% of primary premium *	\$6,040.
Total one year premium	\$18,120.
If the practitioner elected to terminate practice, retire or if the insurance program is terminated, coverage for claims made during a three year discovery period following the last period of primary coverage - 150% of the one year premium	
	\$27,180.
Total one year premium with 3 years discovery	\$45,300.

- * The Commission has subsequently learned that the excess coverage cost is 75% of primary resulting in proportionately higher total costs.



Alaska Pacific Assurance Company

1007 W. THIRD AVE.
ANCHORAGE, ALASKA 99501

August 25, 1975

Medical Malpractice Commission
State of Alaska
C/O Department of Commerce
Pouch D
Juneau, Alaska 99811

ATTN: Richard L. Block

Gentlemen:

This letter is for the purpose of expressing an interest in and some comments regarding a concept being considered by you as a potential device for resolving the programs surrounding the present malpractice situation.

A prerequisite to the plan surrounding the creation of a professional indemnity corporation and the attendant insurance approach to the problem would be the need for certain legislative changes in the existing legal system.

A. Revised Statute of Limitations and Discovery .

We feel that there should be a two or three year statute of limitations and a one year limit on discovery . In discussing a concept it's probably premature to get into specifics. However, in order to convert to this type of program, some device would have to be developed to cover incidents earlier than the three years or four years. In this area, I believe a solution is being explored which would provide for the creation of an indemnity fund, partially by contributions from the medical care providers and partially by the State out of the General Fund.

B. Legislation should provide for some limit on general damages.



Alaska Pacific Assurance Company

Medical Malpractice Commission
August 25, 1975
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C. The broadest possible utilization of collateral sources and the denial of the right of subrogation.

D. Separation of legal fees from awards.

Earlier this month, ALPAC's Vice President of Claims and a representative from our legal firm attended a two-day seminar in San Francisco sponsored by the Professional Lawyers Institute on medical malpractice. This was one of the topics discussed. Rather than the contingency fee situation, to have the legal fees determined by the court or by the arbitration panel.

E. A device for binding arbitration.

Although not requiring legislation, there are a couple of other areas that should be considered in this concept.

1. A screening panel of physicians that would have a non-binding but evidence developing effect on subsequent trials.
2. An improved disciplinary authority, either by the proposed indemnity corporation, or the licensing authority, over medical care providers.

The concept calls for the creation of professional indemnity corporation that would provide a mandatory and exclusive insurance program for all medical care providers. This, more than perhaps any other factor, would make the insurance program viable.

The two most fundamental principles of insurance are the law of large numbers and the spread of risk doctrine. The law of large numbers cannot apply to this situation, but putting the program into one facility maximizes the spread of risk doctrine.



Alaska Pacific Assurance Company

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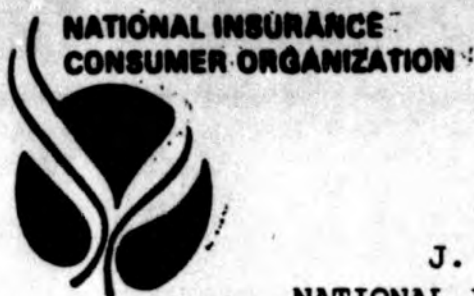
At this point, there is a parallel between the concept being discussed and the insurance program developed for the Alaska Loggers Association. From a workmen's compensation insurance point of view, this is the most hazardous industry in Alaska. Yet, because membership in the association is a prerequisite to insurance, they each enjoy their own individual rates based on their own individual experience; yet collectively their rate is 55% less than the published rate. As the commission explores this concept more in detail, ALPAC would be most interested in working with the commission, exploring such details as to whether the professional indemnity corporation should be established as a casualty insurance carrier and utilize an underwriting manager; whether it should be a pool concept of carriers interested in the project; or whether a servicing carrier supported by its own reinsurance should be the concept; or whatever else might be tailor made from the insurance side to assist.

In summary, this is a viable program and ALPAC would be interested in pursuing it more in detail.

Yours very truly,


John H. Hale
President

JHH/kw



Statement of
J. ~~ROBERT~~ HUNTER, PRESIDENT
NATIONAL INSURANCE CONSUMER ORGANIZATION

Before: The Joint Hearing
of the
House Labor and Commerce Committee
and the
House Judiciary Committee
of the
Alaska State Legislature

April 25, 1989

Mr. Chairman and members of the Committee, it is a great pleasure to be back in Alaska.

I have a question: Why are you still considering so-called "tort reform" when everywhere else the issue is now insurance reform and "tort reform" is a dead issue? There is a good reason for the change. Consider these facts:

*20 States, including Alaska, have sued insurers alleging collusion to create the liability insurance crisis of the mid-1980's --- the predicate for "tort reform."

*California citizens adopted Option 103, wisely recognizing the need to tame the monumental (and uncontrolled) insurance industry.

*We now know that tort reform doesn't lower insurance rates but insurance reform does!

*Key insurance reform proposals have gained widespread support (for example, the effort to repeat the anti-trust exception insurer enjoy in the McCarran-Ferguson Act is supported by both ABA's (Bar and Banker), small businesses,

of Attorneys General), AARP, all consumer groups, environmental groups, civil rights groups, the FTC and the Ford, Carter and Reagan Justice Departments).

I. FROM A CONSUMER VIEWPOINT, WHAT'S WRONG WITH TORT REFORM?

A. "Tort Reform" doesn't lower prices

Given this history, any adoption of Tort Reform without mandatory lower insurance rates is surely buying 'a pig in a poke.'

1. The Aetna and St. Paul Filings. Aetna Casualty and Surety Co. and St. Paul Fire and Marine Co. have undertaken closed claim studies purposing to demonstrate that the savings resulting from five major tort reforms enacted in Florida -- eliminating the collateral source rule, capping non-economic damages, restricting joint and several liability, limiting punitive damages, and requiring periodic payment of future economic damages -- would be negligible. See attachments 1A and 1B.
2. The State Farm letter. State Farm has corroborated the Aetna and St. Paul results. In a letter to the Kansas Insurance Department State Farm concludes, on the basis of "a sampling of commercial liability claims," that the following tort reforms would bring about the following savings:
 - a. eliminating the collateral source rule -- "about 1%";
 - b. non-economic cap -- "will not exceed 1%";
 - c. restricting joint and several liability -- "in our sample of liability claims, no claim was found that would have been affected by the joint and several restriction";
 - d. limiting punitive damages -- "in our sample, no punitive damage awards were found";
 - e. alternative payment of future economic losses - savings "would be negligible."

State Farm also emphasized that "it will probably be several

years before any effect from tort reform legislation can be expected to influence our experience." See Attachment 2.

3. The Florida Insurance Department data. 277 rate filings purporting to calculate the effect of the Florida tort reforms are on file with the Florida Insurance Department. 175, or 63%, showed no effect from the Florida tort changes, and the average reduction in all 277 filings was 1.2%. See Attachment 3. By way of contrast, insurance companies increased premiums in Florida by 62% in 1985, according to NAIC data, and by a similar amount in 1986.

4. The Great American West letter. In Washington state, which enacted perhaps the most comprehensive tort reform package in the nation in 1986, Great American West, Inc. calculated that the new law would, if anything, raise insurance rates. Great American West concluded:

"It does not appear that the 'tort reform' law will serve to decrease our losses, but instead it potentially could increase our liability. We elect at this point, however, not to make an upward adjustment in the indications to reflect the impact of the 'tort reform law.'" See Attachment 4.

5. The ISO Chief Executive Circular. Perhaps most disturbing, the Insurance Services Office has announced that it is issuing "advisory" rates that show no reduction resulting from tort reform, and has emphasized to its member companies that "any beneficial effects of tort reform cannot be quantified with any degree of accuracy" (emphasis ISO's). See Attachment 5. Yet when in 1975 New York enacted tort reform that would expand liability by replacing contributory negligence with comparative negligence, with comparative negligence, and would through raise insurance costs, ISO immediately raised its advisory rates by 5%,

and provided full actuarial justification for the increase. See Attachment 6. It is not readily apparent why ISO can tell us how much rates should rise when tort law expands, but can't tell us how much rates should fall when tort law is limited.

Whether it is good public policy to reduce insurance rates by limiting compensation to seriously injured people is a question on which reasonable minds can differ. But it is clearly not good policy to limit compensation to injury victims and get nothing in return.

B. "Tort Reform" lowers consumer rights and gives them nothing in return.

"Tort reform" takes away from the victim of negligence. It grants nothing in return for this reduction in rights. There should be a quid-pro-quo if Alaska's citizens are to be denied their rights.

C. "Tort Reform" is not based on careful analysis of need.

There have been few careful studies of how victims are treated under the current liability system to determine if there is a problem that needs fixing.

For Texas, where a closed claim study was undertaken, it showed no need for changes in the legal system

To try to find something without understanding what, if anything, is wrong with it, makes no sense.

D. "Tort Reform" lowers the deterrence effect of the legal system.

How could copying the liability of Exxon's oil transport strike you? Or Ford in building Pintos? Or A.F. Robbins in building Dalcom Shields?

America's consumers need the protection of the legal system to deter inappropriate behavior; to stop "crime in the suites."

E. The need for flexibility

People are not chattel. They are not fenders bumped or houses burned. When a drunk driver runs over a breadwinner, or a little girl, or an underwater reef, the penalty must fit the circumstances, both in terms of the victim and the wrongdoers act.

II. WHY DO CONSUMERS WANT INSURANCE REFORM?

A. Insurers are grossly inefficient

"Republican or Democrat, liberal or conservative, there is one thing we can agree on --- waste is bad, inefficiency robs us all."

Andrew Tobias
The Invisible Bankers

"Tobias says we are inefficient and he's right. We spend too much on distribution, overhead and just plain waste."

John Cox, President
Insurance Agency of North America

One of the best service auto liability insurers, USAA, delivers the product at a total overhead cost of twenty cents on the premium dollar. The average insurer requires over thirty-five cents. Prices could fall by 19% if the average insurer becomes as efficient as USAA.

B. Insurers are not well regulated.

Alaska's insurance regulation has historically been, to put it in its most favorable light, non-existent. Often bragging about the highest profits in the nation in its annual report, the Department has not historically protected consumers in this state.

When last I appeared here, I challenged then Director George by saying I doubted that the Department had ever

disapproved a rate. He responded by pointing out that he had too disapproved a rate -- an automobile rate for State Farm -- a decrease!! He said he was afraid State Farm would attract too much business if their rates went down.

How's that for consumer protection?

I don't mean to pick on Alaska, particularly State regulation generally is awful. I am encouraged by the new Director Roller. The U.S. General Accounting Office found "a lack of arms-length relationship between the regulators and the regulated" and that consumers were, generally, not protected by the state insurance departments of the nation.

C. Insurers are not fully competitive

In most states, insurers are structured comparatively. In auto insurance, for instance, 29 states have low concentration (Herfindahl-Hirschman Index below 1000), 21 are moderately concentrated (HHI between 1000 and 2000) and one, Alaska is heavily concentrated (HHI greater than 1000).

So, you have a problem with relying on competition even in the best of competitive worlds.

But insurance is hardly "the best of competitive worlds," viz:

- *it is largely exempt from anti-trust laws (Alaska exempts it from state anti-trust law and the McCarran-Ferguson Act exempts it from federal anti-trust law).

- *it is the last bastion of fair trade laws (the Alaska anti-rebate law makes it unlawful for agents to offer discounts).

- *there are prohibitions on group sales

- *insurance price and service information is hard to understand, if you can find it at all.

Combining these comparative impediments with weak regulation guarantees two things:

- inefficiency and/or
- excessive profits

D. Alaska's profits are excessive

We know insurers are inefficient so profits can be hidden. But profits are too high in Alaska. According to the National Association of Insurance commissioners, Alaska's property/casualty insurance profits are among the highest in the country.

Here are the overall profits for the last decade:

	Premium <u>Earned</u>	Operating <u>Profit</u>	Total Return <u>on Equity</u> Ø	Premium <u>Earned</u> *	Operating <u>Profit</u>	Total <u>Return on</u> <u>Equity</u>
1978	\$285 Million	6.3%	17%	\$80 Billion	5.9'l	16'l.
1979	258	9.1	23	89	4.7	14
1980	257	6.8	19	95	4.6	15
1981	264	3.5	13	97	3.3	13
1982	332	18.0	43	103	0.7	8
1983	412	4.8	17	111	-0.2	7
1984	443	3.1	14	121	-3.2	1
1985	537	-1.9	4	140	-4.1	-
1986	642	3.4	15	176	2.0	13
1987	636	7.1	23	197	3.1	15
Total	\$4,066 Million	5.4%	18%	\$1,209 Billion	1.4%	10'l.

*Source: National Association of Insurance Commissioners, Profitability by line, by state, ten most recent editions.

Ø Estimated by assuming equity to premium rates of 2:1; investment income on equity of 9% latest year decreasing by 0.5'l. by year.

And this national 10% return understates the real economics vitality of their industry. during the same 10 years, the property/casualty industry's common stock have risen by 308'l. vs. 163'l. for the NYSE Composite Index (Source: Bests' Insurance Management Regents, January 1988.

Profitability in 1987 in Alaska for Medical Malpractice was over 50'l. return on equity and for other liability was over 40%r e-turn. But this was a high profit compared to other recent years. Medical malpractice profits in Alaska mirror the national averages over a ten-year review. When the General Accounting Office discounted reserve method of measuring profits is used, the return is about 30% over 10 years. The other liability return in Alaska was lower than the national average of GAO, 26% It was about 12% a good, not excessive return (if you ignore expense inefficiencies).

In 1987, Alaska's leading writers did well, viz:

Leading Medical Malpractice Writers:

	<u>Loss Rates*</u>
1. Medical Indem. Alaska	50.8%
2. Medicine/N.S. Exch.	34.0
3. CNA	66.5
4. Health Care Indem.	56.6
5. Amer. International	53.0

A profitable loss ratio would be about 90%. This shows remarkable profits in 1987.

*Source: Best's Executive Data Service

Alaska's Leading Other Liability Writers

	<u>Incurred/Earned Less Ratio</u>
1. American International	62.9%
2. Alaska National Insurance	33.8
3. Crum & Forster	64.8
4. Nationwide	50.3
5. CNA	50.6

A loss ratio of the order of 85% should be profitable. Again, 1987 was a remarkably good year for insurers in Alaska.

1988 was better, nationally. I do not have 1988 Alaska data as yet.

III. THE SPECIFIC PROBLEM - MEDICAL MALPRACTICE FOR DOCTORS DELIVERING BABIES IN RURAL AREAS

A. A real problem

No one should minimize the serious nature of unaffordability of malpractice insurance in rural areas for doctors delivering babies. Alaska is not alone in having this problem.

B. The Medical Malpractice "Crisis" in Alaska is NOT Due to an Expensive Aggregate System Cost.

If you look at the total costs of the Medical Malpractice system in Alaska it is an inexpensive system. For example, the latest data from the National Association of Insurance Commissioners (NAIC) shows total premiums in Alaska of \$13.6 million during 1987. That's \$28.00 per person (The statistical Abstract of the United States shows 481 Thousand people in Alaska in 1984).

For perspective, the average American spends \$133f per year on tobacco products.

Another way to look at system cost is vis-a-vis total medical costs in the state. According to the Alaska Department of Health, Alaska spent \$2,763 per capita health care costs by 1.0% (\$28.00 divided by \$2,763). I dare say that if you had no system to compensate the victims of malpractice and someone offered to do it for you for a percentage this small, you'd probably grab it.

C. Allocation is the Problem.

The problem is cost allocation, not total system costs. There are only about 550 doctors in Alaska (Statistical Abstract, 1986). This drives the cost very high, to about \$25,000 per doctor on average, some of which may

be positive (because of deterrence effects), but some of which is likely inappropriate.

If you think of the medical profession as a pyramid, with the relatively many G.P.'s at the bottom and the relatively few specialists at the top, I think the problem becomes easier to visualize.

If I wake up in the morning with a bad back and go to my G.P., the likelihood of a major malpractice suit arising is negligible. But if my back is a serious medical problem, I will be referred up the specialty ladder until I get to the neurosurgeon.

At the top of the pyramid, where the number of insureds is least, the risk is greatest. Bad outcomes become more likely. The chance of lawsuit rises, and the cases are much more complex.

I believe it violates insurance spread-of-risk principles to force so much through such a narrow base. (Even though neurosurgeons net income, after med mal premiums, is excellent according to medical economics).

For one thing, why should the defense costs for the complex suits neurosurgeons win be forced to be spread through only the neurosurgeons? Why shouldn't the referring physician and the hospital granting privileges bear some of the cost of successful suits (as incentives for safer referrals/privilege granting)?

The overall system cost is reasonable in your state. Your focus should be on the allocation process, in my estimation.

IV. REINSURANCE PROBLEMS

- A. Lloyds of London, the dominant reinsurance company with approximately 25% of the world-wide market, has been wracked by scandals in recent years.

For example:

o Between 1973 and 1982, two Lloyd's underwriters, Peter Cameron-Webb and Peter Dixon, siphoned off for their own use \$55 million belonging to 1,500 Lloyd's members. Investigators say they used the money for yachts, corporate aircraft, a French orange juice company and a pornographic movie entitled "Let's Do It." see Chicago Tribune, Oct. 20, 1985, at 5; Business Week, Aug. 5, at 57.

o Many of the 1,500 swindled by Cameron-Webb and Dixon are suing Lloyds (although Parliament immunized Lloyds from lawsuits in 1982, the 1,500 are claiming that the immunity doesn't apply to events occurring before 1982). Lloyds, on the other hand, is claiming that the 1,500 owe Lloyds another \$180 million. 100 members face bankruptcy and 200 have been suspended for failing to meet Lloyds' solvency test. See Chicago Tribune, Oct. 20, 1985; Business Week, Aug. 5, 1985.

o Lloyds has grown too fast. In the last decade the number of Lloyds' members has more than tripled to 26,050. Chicago Tribune, Oct. 20, 1985. Since 1981 alone, Lloyds has added 7,000 new members, including "newly rich doctors, lawyers, accountants and rock musicians . . . lured by the hope of annual returns to members that topped 100% some years." Business Week, Aug. 5, 1985. Its total premium writing capacity rose from \$3.4 billion to \$9.4 billion. Id.

- B. In 1982, Lloyds was granted immunity from lawsuits by the British Parliament. Business Week, Aug. 5, 1985, at 58.

- C. Lloyds has threatened, coerced and intimidated both insurers and insureds -- such as states -- in order to keep insurance rates high, as the following statements indicate:

o You may recall this statement:

"If you change your tort laws in Alaska, you will have a market here when the rest of the United States will not. Lloyds is pulling out of the United States as a reinsurer -- they have already pulled out of Connecticut, New York and New Jersey

-- and they're continuing to pull out of more states."

Statement of Jeff Johnson, Partner, LeBoeuf, Lamb, Lieby and McCrae (U.S. counsel for Lloyds), at the Casualty Insurance Colloquium, Anchorage, Alaska, Sept. 17, 1985.

Alaska is not alone:

o ". . . in order to keep [Lloyds] participation on cover we had to accede to some strong suggestions from the reinsurers to beef up the rate charged to the OB's."

Statement of John Spinella, President, Medical Mutual Liability Insurance Society of Maryland, before the Governor's Task Force on Medical Malpractice, Oct. 22, 1985.

o "[reinsurance brokerage head Thomas A.] Green said that beginning in 1986, Lloyd's syndicate would 'simply not write reinsurance for the American casualty industry.'"

Journal of commerce, June 18, 1985.

o "Mr. Wakefield conceded that Lloyds cannot dictate to American regulators on Policy approval, but he wryly

said that if the new form is not approved, Lloyds will not reinsure American liability underwriters."

Journal of Commerce, July 26, 1985, citing C.T. Bowing & Co. Chief Executive Gerald Wakefield, presenting Lloyds' views to 17 insurance commissioners.

o "A Lloyd's of London delegate who flew over expressly for the [insurance commissioner's] meeting added that unless the U.S. industry was permitted to adopt the new form, the lloyds reinsurance market would discontinue backing American underwriters forthwith."

Journal of Commerce, July 27, 1985.

- D. Neither the U.S. government, the states, or the British Parliament regulate Lloyds.
- E. The British pound, which was worth \$2.80 in the mid-1960's has been worth less than half that for most of the last two years and fell to \$1.05 in February 1985. Thus, whereas Lloyds would need to pay only 10,000 pounds to satisfy a \$28,000 claim in 1963, today it must pay 20,000 pounds to satisfy the same claim and in February 1985 -- when the pressure first started to build for tort reform -- it had to pay 26,600 pounds.

V. SOLUTIONS

- A. How to Solve the Insurance Crisis -- What Alaska Should Do
 - 1. Repeal Alaska's Anti-trust Exemption
 - 2. Repeal statutes that prohibit businesses and consumers from joining together to buy insurance in groups. Today, in most states, group health and life insurance is available, but group liability insurance is illegal. If laws prohibiting such group insurance were repealed, the price of liability insurance would fall.

3. Prohibit rate increased from taking effect until such increases are approved by the insurance commission. Today, in most states, increases automatically take effect unless disapproved within a certain number of days; because the burden is on the insurance commission to disapprove a rate, and because insurance commissions do not have the staff to analyze even a fraction of rate filings, most increases automatically take effect. Shifting the burden of proof to the insurance company to demonstrate that a rate increase is justified would limit such increases.
4. Allow greater consumer representation before regulatory bodies. Typically, only regulators and insurance companies participate in rate cases. To increase citizen participation in the ratemaking process, states should authorize Citizens' Insurance Boards, groups of insurance consumers who would intervene on their own behalf. In the alternative, states could establish Offices of Public Advocates to intervene in rate cases, as New Jersey and some other states have. In New Jersey when the Public Advocate intervenes in a rate case the cost of that intervention is billed back to the insurance company seeking the rate increase, thus discouraging insurers from seeking exorbitant increases.
5. Require that insurance rates be based on experience. Because insurance companies today often lump all insureds in a category together, regardless of how often any individual insured has been sued, good risks currently subsidize bad risks. Experience rating would go a long way toward bringing down premiums for medical malpractice insurance, in which experience rating is now virtually non-existent.

6. Enact tough conflict-of-interest statutes to close the "revolving door." As the U.S. General Accounting Office has found, 50% of state regulators come from and return to the industry; the relationship between the industry and the regulators is not an arms-length relationship.
7. Require that insurance companies disclose their loss data on a line-by-line basis. Such disclosure would enable regulators to better discern whether rates are excessive, inadequate or unfairly discriminatory.
8. Establish state reinsurance programs.
9. Beef up the Insurance Department both authoritatively and with resources.
10. Repeal the state anti-rebate law.
11. Publish buyers guides with price and service information.

B. Medical Malpractice

Render the above:

1. Lessen the number of classes.
2. Let hospitals bear part of the cost for adverse procedures in the hospital. Consider channeling doctors malpractice costs through hospitals.
3. Consider a specific subsidy in rural areas for physicians consider additn a malpractice charge on all health insurance premium as a subsidy dollar base.
4. Attract more physicians to Alaska to normalize the patient/doctor ratio.

VI. WHY CONSUMERS OPPOSE HOUSE BILL NO. 166

Generally:

1. We lose rights.
2. We get nothing in return (such as a victim's reparations regime).
3. It treats us like a fender, not a person.
4. It won't work to lower rates and make insurance more available.
5. It lowers deterrence.
6. There is no study showing need for change.

It specifically has these problems, among others.:

1. Lets faulty product manufacturers or bad surgeons off the hook if six years go by before the product blows up or the sponge works its way into someone's heart.
2. Fixes the possibly real problem of collateral source in exactly the opposite (and wrong) way. While no one should collect twice for the same injury, the wrong doer should pay, not our policies. Our rate should go down, not drunk drivers.

mandate subrogation and order lower health insurance rates.
3. Creates inter-family problems by limiting a baby's right to sue to two years ending special treatment for minors.
4. It limits our freedom to choose the sort of settlement we want, lump sum or structured.
5. It creates a disincentive for insurers to pay (as if they needed any more) by charging them below market interest if they delay.
6. It caps non-economic damages in wrongful death cases at a pitiful \$50,000.

VI. CONCLUSION

Alaska needs reform that works -- Alaska needs insurance reform. Like other smaller population states, large multinational insurers can hold you hostage. You may well need consider working for interstate compacts with larger states to avoid the kind of under pressure Lloyds and others have brought to bear here. And other states are moving. Almost every state has insurance reform bills before the legislature. Little New Mexico voted to repeal that state's anti-trust exemption, but the governor vetoed it under intense pressure from the insurers. Arizona has many reform bills before it. South Carolina is moving a bill. Maryland returned to prior approval. The Texas Senate late last week voted to repeal that state's anti-trust exemption. The Chairs of the U.S. Senate and House Judiciary Committees have introduced bills to end McCarran's broad anti-trust immunity.

Now is the time for insurance reform. I pledge NICO's assistance to you in achieving such real reform.

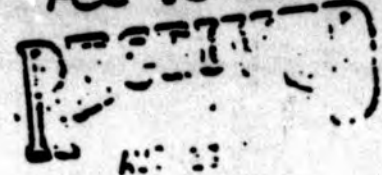
Thank you. I would be happy to answer your questions when that is appropriate.



Commercial Insurance Division
151 Farmington Avenue
Hartford, CT 06156
(203) 273-0123
August 8, 1986

Attachment 1A

FCC-86-2172



REGIONS AND CONTRACTS

Honorable Bill Guter
INSURANCE COMMISSIONER
Florida Department of Insurance
Tallahassee, FL 32301

ATTN: Mr. Charlie Gray, Chief
Bureau of Policy and Contract Review

Dear Mr. Gray:

RATE REVISION
CONTRACTORS LIABILITY POLICY PROGRAM
✓ THE AETNA CASUALTY AND SURETY COMPANY
THE STANDARD FIRE INSURANCE COMPANY
THE AUTOMOBILE INSURANCE COMPANY OF HARTFORD, CONNECTICUT

In accordance with your Insurance Laws, our Companies file a revised liability rate level which results in an overall selected premium increase of 17.22 with an annual premium effect of \$622,250.

Our Companies' decision to revise rates results only after a thorough and comprehensive analysis. We evaluated our experience, market conditions, tort reform, and other relevant factors as they affect the establishment of adequate rate levels. The enclosed exhibits prepared by actuarial unit are submitted in support of our rate filing decision, and demonstrate that the resultant rates are neither excessive, inadequate, nor unfairly discriminatory.

We propose to implement this filing with respect to all policies written on or after January 1, 1987. So as to not delay the filing of our rate level decision, revised rate pages will be forwarded under separate cover when available.

A stamped, self-addressed envelope is enclosed for your convenience in responding.

Sincerely,

Thomas L. Rudd, Superintendent
Insurance Department Affairs - Commercial Lines

The Aetna Casualty and Surety Company
One of the AETNA LIFE & CASUALTY companies

3. Fifty closed claims with indemnity of less than \$25,000 were randomly selected.

The completed forms were reviewed for internal consistency prior to coding and analysis.

Collateral Source Analysis

Exhibits I and II detail the analysis of the revision in the collateral source rules. Exhibit I is for claims over \$25,000 indemnity. Exhibit II is for claims under \$25,000 indemnity.

Exhibit I shows that since the right of subrogation exists for many collateral sources available to the plaintiff, the economic losses incurred are not expected to be substantially reduced due to the law change. Furthermore, current Aetna claim settlement practices recognize, in part, the existence of collateral sources as part of the negotiating process used in arriving at a mutually satisfactory damage value with the plaintiff.

Exhibit II shows that for claims under \$25,000, no additional savings are expected due to the change in Florida law.

Joint and Several Analysis

Exhibit III details the analysis of joint and several additional payments made by Aetna. Total joint and several payments were 4.5% of indemnity payments over \$25,000. A review of each claim generating additional payments due to joint and several liability indicated no reduction in those payment due to the interaction of economic damages sustained by the plaintiff, the percentage of liability assigned to Aetna's insured, and the policy limits purchased.

Analysis of Limitation of Noneconomic Damages to \$450,000

Nine claims had the potential for coming under the new limitation for noneconomic losses. The nine cases were identified on the basis of full liability value—not our insured's share of the liability. Data in the above format allowed for a review of whether total claim value could be reduced and whether such a reduction would impact on Aetna's incurred claim cost.

The review of the actual data submitted on these cases indicated no reduction of cost. This result is due to the impact of degree of disability on future losses, the impact of policy limits, and the actual settlement reached with the plaintiff; all seemed to reduce the expected noneconomic component of damages to less than \$450,000.

Analysis of Punitive Damages

Only two cases were found where punitive damages had an impact on the claim settlement value. The total impact was estimated at less than \$15,000 or less than 0.1% of total indemnity payments. Consequently, it appears that there will be no impact on Aetna's claim values due to changes in the allocation of the punitive damages awarded.

CORRECTION

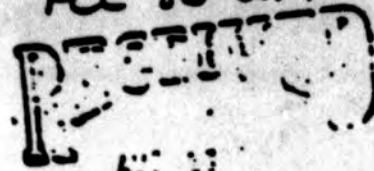
**THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY**



Commercial Insurance Division
151 Farmington Avenue
Hartford, CT 06155
(203) 273-0123
August 8, 1986

Attachment 1A

FCC-86-2172



ECRMS AND CONTRACTS

Honorable Bill Gunter
INSURANCE COMMISSIONER
Florida Department of Insurance
Tallahassee, FL 32301

ATTN: Mr. Charlie Gray, Chief
Bureau of Policy and Contract Review

Dear Mr. Gray:

RATE REVISION
CONTRACTORS LIABILITY POLICY PROGRAM
✓ THE AETNA CASUALTY AND SURETY COMPANY
THE STANDARD FIRE INSURANCE COMPANY
THE AUTOMOBILE INSURANCE COMPANY OF HARTFORD, CONNECTICUT

In accordance with your Insurance Laws, our Companies file a revised liability rate level which results in an overall selected premium increase of 17.2% with an annual premium effect of \$622,250.

Our Companies' decision to revise rates results only after a thorough and comprehensive analysis. We evaluated our experience, market conditions, tort reform, and other relevant factors as they affect the establishment of adequate rate levels. The enclosed exhibits prepared by actuarial unit are submitted in support of our rate filing decision, and demonstrate that the resultant rates are neither excessive, inadequate, nor unfairly discriminatory.

We propose to implement this filing with respect to all policies written on or after January 1, 1987. So as to not delay the filing of our rate level decision, revised rate pages will be forwarded under separate cover when available.

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Sincerely,

Thomas L. Rudd, Superintendent
Insurance Department Affairs - Commercial Lines

BODILY INJURY CLAIM COST IMPACT OF FLORIDA TORT LAW CHANGE

Summary

The following table summarizes the expected impact of the new Florida law on bodily injury claims costs (including Allocated Loss Adjustment Expenses). The impacts shown were developed from data gathered via a special claim study conducted by the Aetna. The claim study and the analysis are detailed in the succeeding sections of this memorandum.

Impact of Tort Law Changes

Impact of Tort Law Changes

<u>Tort Law Change</u>	<u>Line of Business</u>	
	<u>Products</u> <u>Bodily Injury</u>	<u>All Other</u> <u>General Liability</u>
Collateral Source Offset	0	(0.4X)
Joint & Several	0	0
Limitation of Noneconomic Damages to \$450,000	0	0
Punitive Damages	0	0
Future Economic Damages over \$250,000 Paid at Present Value	0	0

All Other General Liability includes the bodily injury liability portion of package policies, SMP Section II, and monoline General Liability policies. The analysis as shown is based solely on Aetna data and, therefore, is applicable only to Aetna's book of business.

Claim Study

The attached special claim analysis form, designed to gather data on the impact of the tort reforms, was completed by experienced Branch Office claim personnel. Claims eligible for analysis were selected according to the following criteria:

1. Commercial Casualty claims (excluding National Accounts business) for policy years 1981 through 1985
 - a. reported prior to January 1, 1986
 - b. open as of May, 1986
 - c. closed during the last six months
2. All claims in category (1) with indemnity payments or reserves over \$25,000 were analyzed (total of 55 claims).

3. Fifty closed claims with indemnity of less than \$25,000 were randomly selected.

The completed forms were reviewed for internal consistency prior to coding and analysis.

Collateral Source Analysis

Exhibits I and II detail the analysis of the revision in the collateral source rules. Exhibit I is for claims over \$25,000 indemnity. Exhibit II is for claims under \$25,000 indemnity.

Exhibit I shows that since the right of subrogation exists for many collateral sources available to the plaintiff, the economic losses incurred are not expected to be substantially reduced due to the law change. Furthermore, current Aetna claim settlement practices recognize, in part, the existence of collateral sources as part of the negotiating process used in arriving at a mutually satisfactory damage value with the plaintiff.

Exhibit II shows that for claims under \$25,000, no additional savings are expected due to the change in Florida law.

Joint and Several Analysis

Exhibit III details the analysis of joint and several additional payments made by Aetna. Total joint and several payments were 4.5% of indemnity payments over \$25,000. A review of each claim generating additional payments due to joint and several liability indicated no reduction in those payment due to the interaction of economic damages sustained by the plaintiff, the percentage of liability assigned to Aetna's insured, and the policy limits purchased.

Analysis of Limitation of Noneconomic Damages to \$450,000

Nine claims had the potential for coming under the new limitation for noneconomic losses. The nine cases were identified on the basis of full liability value—not our insured's share of the liability. Data in the above format allowed for a review of whether total claim value could be reduced and whether such a reduction would impact on Aetna's incurred claim cost.

The review of the actual data submitted on these cases indicated no reduction of cost. This result is due to the impact of degree of disability on future losses, the impact of policy limits, and the actual settlement reached with the plaintiff; all seemed to reduce the expected noneconomic component of damages to less than \$450,000.

Analysis of Punitive Damages

Only two cases were found where punitive damages had an impact on the claim settlement value. The total impact was estimated at less than \$15,000 or less than 0.1% of total indemnity payments. Consequently, it appears that there will be no impact on Aetna's claim values due to changes in the allocation of the punitive damages awarded.

Analysis of Installment Payment of Future Economic Damages Over \$250,000

Ten claims had the potential for coming under this section of the law. The review of individual cases indicated no net savings to Aetna for the following reasons:

1. interaction of policy limits, past economic losses, and future economic losses
2. settlement value of the case
3. apparent implicit recognition of the periodic nature of future damages

Overall Summary

The expected net reduction in claim costs is based on an analysis of Aetna claims. As such, the analysis is applicable only to Aetna's book of business.

Due to the level of detail of the historical claim data, informed claim judgement was required in some instances to ascertain some of the detail required for the analysis. The judgement, if any, was exercised by experienced claim adjusters and is implicit in the analysis.

The analysis shown represents the best estimate of future cost reductions if the law as currently structured remains in effect. However, the sunset provision of the law takes effect in four years. Furthermore, the law applies only to cases filed under the law, and the Florida statute of limitations is four years. Consequently, it is possible that any plaintiff who might be severely impacted by the provisions of the law would delay filing until after the law expires. If this situation arises, then the expected reductions will be lower than those indicated in this memorandum.

St. Paul Fire and Marine Insurance Company
St. Paul Mercury Insurance Company
Medical Professional Liability
State of Florida

ADDENDUM

In 1986, Florida passed a number of changes to the tort system. We have reviewed the tort changes and their potential effect on our medical professional liability experience. Our review is based on a study of over 300 Florida closed claims. The total effect of the bill based on this evaluation was very small.

Evaluation:

Of the 313 closed claims that were studied, only four claims would have been effected by the law for a total effect of about 1% savings. (Exhibit A) Furthermore, all of these savings would have been eliminated if the courts had assigned only 10% more of the blame on our insureds than our claim department had estimated. It's highly likely that there would have been no savings on these claims had the bill been in effect. (Exhibit B)

Our study covered all of our Florida physicians, surgeons and hospital claims that closed in 1983 and 1984. Economic loss was determined based on the plaintiff's medical loss, weekly wage, and time lost from work. These losses were reduced for the time value of money.

We added the noneconomic loss cap to the total economic losses. The cap is \$450,000 times the portion of negligence assigned to our insured. We compared this maximum award under the new law to the amount that the St. Paul actually paid on behalf of our insured.

The conclusion of the study is that the noneconomic cap of \$450,000, joint and several liability on the noneconomic damages, and mandatory structured settlements on losses above \$250,000 will produce little or no savings to the tort system as it pertains to medical malpractice.

Comments on other provisions of the bill:

a. Collateral source offset

The medical malpractice provisions prior to this act provided for subrogation against collateral providers. The effect of this subrogation would be similar to the effect of the collateral source rule. Therefore, the net effect of eliminating the subrogation and allowing collateral sources is negligible.

b. Itemization of Damages

Damages were itemized in our evaluation of this tort reform and no savings were shown. They are probably already implicitly itemized by either juries or our claim department when settling claims. We expect no savings from this provision.