

ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672

4628 HJUD INSURANCE OVERVIEWS (JNT. WITH HOUSE L&C)

ie law, national,
 rds, and other
 e considered;
 nsidered;
 se categories of
 ations shall be
 y given year are
 riting expense,
 any loans, the
 irector, levy an
 g that year; the
 nents, shall be
 er cent of the
 policy does not
 sured's propor-
 accrued while

any given year
 se, reserves for
 he corporation
 tion and pay or
 a payment or
 emium for that

y issue a certif-
 a portion of an
 of this section
 e is issued, and
 this section in
 certificate is
 actuarial basis
 voke the certif-
 subject to the
 eriod for which
 cy may not be
 of the insured.
 978; am § 5 ch

"insured's" for
 ddle of paragraph
 at rewrote para-

Sec. 21.88.090. Payment of premiums; cancellation of insurance. The corporation may provide for installment payment of premiums in which case each installment is due by the date specified. The corporation may cancel any of its policies in the event of nonpayment of any premium or installment on a premium, or other charge, by mailing or delivering to the insured at the address shown on the policy and to the agency of the state issuing the insured's license written notice of cancellation. Cancellation is not effective until 30 days after the date notice is posted by the corporation. (§ 41 ch 102 SLA 1976)

Sec. 21.88.095. Transfer of corporate assets and liabilities. (a) The corporation may, subject to the prior approval of the director, transfer its assets and liabilities to a company which meets all of the following conditions:

(1) the company possesses a valid certificate of authority to transact casualty insurance business in the state; in evaluating the capital and surplus of the company for qualification for a certificate of authority, the value of the assets and liabilities transferred by the corporation may not be considered;

(2) the company pays to the corporation the full value of any surplus in the corporation not represented by any unrepaid proceeds of loans by the loan fund to the corporation;

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

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

(A) to assume the obligations;

(B) that, if at any time the company writes less than the premium levels provided in AS 21.88.055(a), the director may determine that the loan provisions shall be modified to provide a scheduled amortization repayment of the principal over a period not to exceed 10 years and at an interest rate of four points above the federal discount rate, as that rate is adjusted from time to time; and

(C) that the provision for repayment provided in AS 21.88.210(b)(1) shall be modified to provide for annual installments of at least 25 per cent of the excess of premium and investment income collected over the total of claims, reserves and expenses on the Alaska medical malpractice book of business or 25 per cent of the excess of premiums and investment income collected over the total of claims, reserves and expenses on the corporation's total book of business, whichever is greater;

(5) the company meets such other requirements as the director may reasonably require to protect the interests of the state, the health care provider insureds, the involved company, and the public;

(6) the company provides the board of governors with a written statement from the director that the company qualifies under (1) — (5) of this subsection.

(b) If and while the company to which the assets and liabilities of the corporation are transferred in the manner provided in (a) of this section continues to write premiums in excess of the levels provided in AS 21.88.055, it shall enjoy the benefit of the following provisions:

(1) the company is entitled to carry forward and offset against its premium tax obligation to the state the amount by which the aggregate claims paid on reinsurance assumed under (a)(3) of this section exceeds aggregate reserves on the same business established at the date of the reinsurance agreement; and

(2) the obligation to repay to the loan fund loans assumed by the company at the time of transfer of the assets and liabilities of the corporation need not be shown as a liability on the books of the corporation. (§ 16 ch 177 SLA 1978)

*Secs. 21.88.110 — 21.88.180. Joint Underwriting Association.
[Repealed, § 40 ch 177 SLA 1978.]*

Article 3. Loan Fund.

Section

210. Fund established

Sec. 21.88.210. Fund established. (a) There is in the Department of Commerce and Economic Development a medical malpractice liability revolving loan fund to be administered by the director of insurance.

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

(1) to provide surplus in respect to policyholders which may not exceed a total of \$3,000,000 outstanding at any time; these obligations shall be subordinated to all other obligations of the corporation; loans made under this paragraph shall be repaid to the fund in annual installments of at least 25 per cent of the excess of premiums earned over the total of claims, reserves, expenses, and assessments made by the association, if any; interest shall be paid on the outstanding balance at a rate equal to seven per cent a year;

(2) if the director determines that the corporation is unable to procure reinsurance from a private casualty insurer or reinsurer for any liability incurred by contracts issued by it, additional loans up to an aggregate of \$6,000,000 when taken together with loans made under (1) of this subsection to compensate for fluctuations in loss experience; loans made under this paragraph shall be in parity with all other obligations of the corporation except that they shall be subordinated to obligations of policyholders and claimants for indemnity of loss; these loans shall be repaid within five years at an annual interest rate of six per cent.

liabilities of the
) of this section
provided in AS
provisions:
set against its
the aggregate
section exceeds
the date of the

ssumed by the
abilities of the
of the corpora-

g Association.

he Department
practice liabil-
or of insurance.
tion upon certi-
er the following

which may not
ese obligations
poration; loans
und in annual
emiums earned
ments made by
utstanding bal-

s unable to pro-
ir surer for any
l loans up to an
ans made under
loss experience;
with all other
subordinated to
ty of loss; these
erest rate of six

(c) If a loan is made to the corporation from the fund, the corporation shall issue a note to the fund as evidence of the loan.

(d) The director may sell at par value to the Department of Revenue the notes, security instruments and pledge agreements held by the Department of Commerce and Economic Development as security for loans made under this section. The Department of Revenue shall purchase all the notes offered until the current principal amount of the notes purchased and held by the Department of Revenue equals \$6,000,000. (§ 41 ch 102 SLA 1976; am §§ 17, 18 ch 177 SLA 1978; am § 6 ch 103 SLA 1980)

Effect of amendments. — The 1980 "collected" near the middle of paragraph amendment substituted "earned" for (1) of subsection (b).

Article 4. General Provisions.

Section

900. Definitions

Sec. 21.88.900. Definitions. In this chapter

- (1) "chiropractor" means a person licensed under AS 08.20;
- (2) "continuous coverage" means one or more successive policy periods which is uninterrupted by cancellation or failure to renew for any period;
- (3) "corporation" means the Medical Indemnity Corporation of Alaska;
- (4) "covered claim" means
 - (A) a claim by an injured patient reported to the corporation during the period of continuous coverage by the corporation of the insured health care provider for an act or omission in the delivery of health care services; and
 - (B) additional claims as defined in the policy, with the prior approval of the director, and which are reported within specified periods after the expiration of the policy;
- (5) "dental hygienist" means a person licensed under AS 08.32;
- (6) "dentist" means a person licensed under AS 08.36;
- (7) "dispensing optician" means a person licensed under AS 08.71;
- (8) "governor" means a member of the board of governors of the Medical Indemnity Corporation of Alaska;
- (9) "health care provider" means a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; a hospital as defined in AS 18.20.130, including a governmentally owned

Chapter 88. Health Care Providers Insurance.

Article

4. General Provisions (§ 21.88.900)

Article 4. General Provisions.

Section

900. Definitions

Sec. 21.88.900. Definitions. In this chapter

- (1) "chiropractor" means a person licensed under AS 08.20;
- (2) "continuous coverage" means one or more successive policy periods which is uninterrupted by cancellation or failure to renew for any reason;
- (3) "corporation" means the Medical Indemnity Corporation of Alaska;
- (4) "covered claim" means
 - (A) a claim by an injured patient reported to the corporation during the period of continuous coverage by the corporation of the insured health care provider for an act or omission in the delivery of health care services; and
 - (B) additional claims as defined in the policy, with the prior approval of the director, and which are reported within specified periods after the expiration of the policy;
- (5) "dental hygienist" means a person licensed under AS 08.32;
- (6) "dentist" means a person licensed under AS 08.36;
- (7) "dispensing optician" means a person licensed under AS 08.71;
- (8) "governor" means a member of the board of governors of the Medical Indemnity Corporation of Alaska;
- (9) "health care provider" means an audiologist licensed under AS 08.11; a chiropractor licensed under AS 08.20; a dental hygienist licensed under AS 08.32; a dentist licensed under AS 08.36; a nurse licensed under AS 08.68; a dispensing optician licensed under AS 08.71; an optometrist licensed under AS 08.72; a pharmacist licensed under AS 08.80; a physical therapist licensed under AS 08.84; a physician licensed under AS 08.64; a podiatrist; a psychologist and a psychological associate licensed under AS 08.86; a hospital as defined in AS 18.20.130, including a governmentally owned or operated hospital; a corporate entity covered under AS 21.88.050(b)(11); an employee of a health care provider acting within the course and scope of employment;
- (10) "hospital" means an institution licensed under AS 18.20;
- (11) "nurse" means a person licensed under AS 08.68;
- (12) "optometrist" means a person licensed under AS 08.72;
- (13) "pharmacist" means a person licensed under AS 08.80;
- (14) "physical therapist" means a person registered under AS 08.84;

Insurance.

AS 08.20;
Insurance policy pe-
riod to renew for

Corporation of

Insurance during
life of the insured
policy of health

At the prior ap-
pointed periods

Under AS 08.32;
08.36;

Under AS 08.71;
Governors of the

Licensed under AS
Medical hygienist li-
censed under AS
Nurse licensed
08.84; a physi-
cian and a psy-
chologist as defined in
AS 08.84; an em-
ployee of a
hospital or em-
ployee of employ-

AS 18.20;
08.68;
AS 08.72;
AS 08.80;
Under AS 08.84;

(15) "physician" means a person licensed under AS 08.64;

(16) "psychologist" and "psychological associate" mean a person licensed under AS 08.86. (§ 41 ch 102 SLA 1976; am §§ 19, 20, 40 ch 177 SLA 1978; am § 6 ch 46 SLA 1982; am § 10 ch 131 SLA 1986)

Effect of amendments. — The 1986 amendment inserted "an audiologist li- censed under AS 08.11" preceding "a chi- ropractor" in paragraph (9).

Chapter 90. General Provisions.

Section

30 — 110. [Repealed]

900. Definitions for title

Secs. 21.90.030 — 21.90.110. Definitions. [Repealed, § 23 ch 21 SLA 1985. For current law see AS 21.90.900.]

Sec. 21.90.900. Definitions for title. In this title, unless the context requires otherwise,

(1) "alien insurer" means an insurer formed under the laws of a country other than the United States of America, its states, districts, territories, and commonwealths;

(2) "authorized insurer" means an insurer authorized by subsisting certificate of authority issued by the director to transact insurance in this state;

(3) "commissioner" means the commissioner of the Department of Commerce and Economic Development;

(4) "court" means superior court;

(5) "director" means the director of the division of insurance;

(6) "division" means the division of insurance, Department of Commerce and Economic Development;

(7) "domestic insurer" means an insurer formed under the laws of this state;

(8) "foreign insurer" means an insurer formed under the laws of a jurisdiction other than this state and includes an alien insurer;

(9) "industrial life insurance" means that form of life insurance written under policies with a face amount of \$1,000 or less, with the words "industrial policy" imprinted on the face as part of the descriptive matter, and under which premiums are payable monthly or more often;

(10) "insurance" means a contract whereby one undertakes to indemnify another or pay or provide a specified or determinable amount or benefit upon determinable contingencies;

(11) "insurer" includes a person engaged as indemnitor, surety, or contractor in the business of entering into contracts of insurance or of annuity;

M I C A

**1985
Tenth Annual Report**

Medical Indemnity Corporation of Alaska

CORPORATE DIRECTORY

Board of Governors

David J. Frazier
Chairman of the Board
William G. Brock
First Vice Chairman
Robert D. Whaley, M.D.
Secretary Vice Chairman
David Grauman, M.D.
Frederick R. Hood, M.D.
Renee Murray
Mary A. Pierce
Jane Sabes
Kim C. Smith, M.D.

Board of Governors Committees

Executive Committee

David J. Frazier - Chairman
William G. Brock - 1st Vice-Chairman
Robert D. Whaley, M.D.
2nd Vice-Chairman

Audit Committee

David S. Grauman, M.D. - Chairman
Kim C. Smith
Frederick R. Hood, M.D.

Claim Committee

Renee Murray - Chairman
Frederick R. Hood, M.D.
Robert D. Whaley, M.D.

Computer Committee

Robert D. Whaley, M.D. - Chairman
Frederick R. Hood, M.D.
David S. Grauman, M.D.

Finance & Investment Committee

William G. Brock - Chairman
Mary Pierce
Jane Sabes

Underwriting Committee

Mary Pierce - Chairman
David S. Grauman, M.D.
Renee Murray
Jane Sabes
Robert D. Whaley, M.D.

Legislative Committee

Kim C. Smith, M.D. - Chairman
Robert D. Whaley, M.D.
William G. Brock

Risk Management Committee

Frederick R. Hood, M.D., - Chairman

Advisory Panel:

William Compton, M.D.
Scott Emery, M.D.
Hedric Hanson, M.D.
Kitchener Head, M.D.
Burton Janis, M.D.
Warren Jones, J.D.
Ron Keller, M.D.
Lorraine Kottra, M.D.
Scott Sims, M.D.

Corporate Office

Alaska U.S.A. Office Building
4000 Credit Union Drive, Suite 525
Anchorage, Alaska 99503

Administration

Peter J. Volpe, Director
Vice President
Marsh & McLennan, Incorporated
720 Olive Way
Seattle, Washington 98101
(206) 223-1240

Local:

Arthur M. Stanford
Manager/Assistant Director
4000 Credit Union Drive, Suite 525
Anchorage, Alaska 99503
(907) 563-3414

Janet Sloan Johnston, R.N., M.S.N.
Assistant Director
(Claims-Risk Management)

Staff

Donnette Olsen Norman
Office Manager

Joe McKay
Amy Murphy
Harriett Larson

Actuaries

David R. Bickerstaff, F.C.A.S.
Milliman & Robertson, Incorporated
251 South Lake Avenue, Suite 400
Pasadena, California 91101

Auditors

Ernst & Whinney
301 W. Northern Lights Blvd., Suite 601
Anchorage, Alaska 99501
(907) 279-1411

Corporate Counsel & Secretary

Roger F. Holmes, Esq.
BISS & HOLMES
705 Christensen Drive
Anchorage, Alaska 99501

Assistant Corporate Secretary

Patricia Baker
3120 Bettles Bay Loop
Anchorage, Alaska 99502

Data Services

Mark Bolzern
General Computer Services
200 W. 34th Avenue, Suite 798
Anchorage, Alaska 99503
(907) 563-2707

Investment Consultants

Donald E. Boyd
Vice President
Wells Fargo Investment Advisors
P.O. Box 44029
San Francisco, California 94144
(415) 396-6436

Reinsurance Intermediary

Kendel Lyman - Vice President
Marsh & McLennan, Incorporated
720 Olive Way
Seattle, Washington 98101
(206) 223-1240

Cravens & Company, S.I.S.
800 5th Avenue, #378
Seattle, Washington 98104

Reinsurers

Certain underwriters at Lloyds,
British Companies

Domestic:
Health Providers Insurance Co.
211 E. Ontario
Chicago, Illinois 60611

Risk Management Consultant

Robert S. Brittain, M.D.
President
Medical Liability Consultants Program
Bldg. 2, Suite 199
6825 E. Tennessee
Denver, Colorado 80224
(303) 321-3884

CONTENTS

Corporate Directory	1
Chairman's Message	2
Claims	3
Risk Management	4
Underwriting	6
Investments	7
Financial Statements	9
Medical Malpractice Update	14

CHAIRMEN'S MESSAGE

The Medical Indemnity Corporation of Alaska has completed another year of operation which was the most dynamic since its incorporation in 1976. The year saw many changes in the way our corporation operates and views its role in the state of Alaska. There were many factors which contributed to our successes and disappointments during 1985. I would like to share with you several of the challenges that were presented to your Board of Governors during the year.

Even though MICA is a relatively small medical liability insurance company compared to our counterparts in the Lower 48, MICA prides itself on retaining only the most qualified advisors available inside and outside the state of Alaska. One of the most important consultants retained is our independent actuary who attempts to predict with a reasonable degree of certainty our anticipated claims volume and claims severity. Our efforts in 1985 to encourage early reporting of potential claims may have resulted in a claims volume that exceeded our expectations, as well as that of our actuary. This claims volume placed a temporary but substantial pressure on our financial resources, and for that reason, our 1985 financial statement does not reflect the margin of surplus we experienced during most of our previous years of operation.

Another very significant issue presented to the Board of Governors during 1985 was the fact that a large

number of national and international reinsurers had begun or had totally withdrawn from writing business associated with the medical malpractice market. This unpredictable and possible unavailability of any reinsurance, presented unique problems to the MICA Board as to the amount of policy limits we could realistically provide, in the absence of reinsurance. Fortunately, we were able to negotiate a reinsurance contract for 1985 but we were unable to procure reinsurance for the higher limits of liability offered by MICA in previous years. We anticipate that this reinsurance problem may continue for some time, and we are committed to continue offering only policy limits which MICA can support and still remain fiscally sound today and in the future.

In response to the dramatically increasing claims costs and substantially greater reinsurance premiums, MICA had no alternative except to raise premiums in 1985. Certainly, the increase was greater than we would have initially anticipated for the year, but the adjustment was actuarially sound and clearly justifiable under the circumstances.

Your Board is very pleased with the performance of its Risk Management Committee and staff. Unquestionably, our ongoing communications program with our policyholders is a fine example for others in our industry. We have taken a leadership role in the development of a creative risk management program that has brought not

only acceptance but accolades from MICA insureds and which we are confident will pay substantial dividends to the MICA program in the years ahead.

The Medical Indemnity Corporation of Alaska is now completing its tenth year of operation in the state. During that time, MICA has strived to provide adequate protection to its insureds and to those receiving medical care in this state. We have met frequently and worked diligently to create a health care environment that is conducive to the well-being of all our citizens. Although we operate a professional and efficient insurance organization, MICA is still subject to the same judicial vagaries that other medical liability insurance companies face throughout the country. For that reason, MICA undertook a position in 1985 to support tort reform that would be fair to private individuals, our insureds, and the company. We have taken a strong stand in support of legislation that will provide positive change to the legal system and thus promote the best interest of Alaskans. We are confident that the Alaska Legislature will enact changes to the tort system that will ensure the uninterrupted and quality health services needed and deserved by all Alaskans.

Finally, we would like to thank those physicians, hospitals and other health care providers that have given support and aid to the Medical Indemnity Corporation of Alaska. Their recognition of the importance of having a company that can respond to the local

needs of Alaskan insureds and its citizens is heartwarming. We appreciate the efforts of our MICA staff and the many persons who have volunteered to assist MICA during its growing years. We are confident that MICA's second decade will be as positive and dynamic as its first.

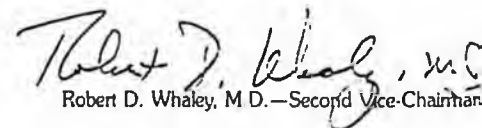
Respectfully submitted,



David J. Frazier—Chairman



William G. Brock—First Vice-Chairman



Robert D. Whaley, M.D.—Second Vice-Chairman

CLAIMS

The graph to the right illustrates the continuing escalation of claims reported by MICA policyholders since the company's incorporation in 1976.

We have added a new column for 1985 entitled, "Suspense Files" as distinguished from reported claims. This new category relates to incidents reported to MICA which have some elements realistically associated with a legitimate claim, but no claim has actually been made to date. Although these potential claims are thoroughly investigated to provide the best possible defense to our insureds, they continue to be termed "suspense" files until the patient or the patient's attorney actually makes a demand for compensation. An exception to this rule is to open a claims file when the medical misadventure resulted in serious consequences and in our judgement, will most likely result in a demand for compensation at some future date.

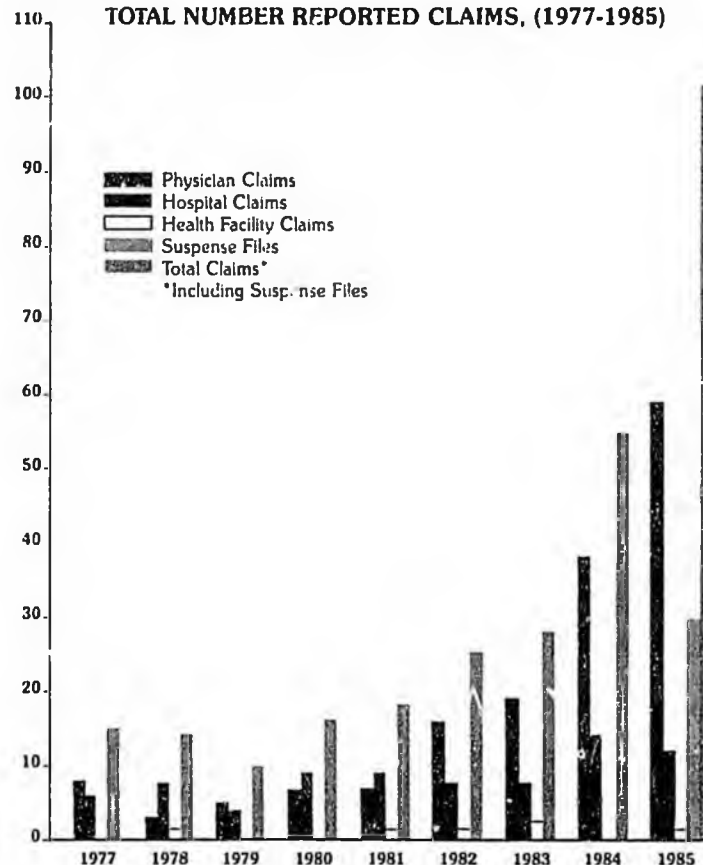
MICA remains the only medical malpractice insurance carrier in Alaska with a local, "in-house" Claims Department. Our Claims Department is staffed by a registered nurse who conducts all initial investigations of potential claims. She is supported and assisted by MICA's manager who has a background of over 30 years of casualty claims experience. She also draws upon the medical expertise of the physicians on the MICA Board of Governors and Risk Management Committee.

The first steps taken by MICA's Claims Administrator on a newly reported claim are to conduct an in-

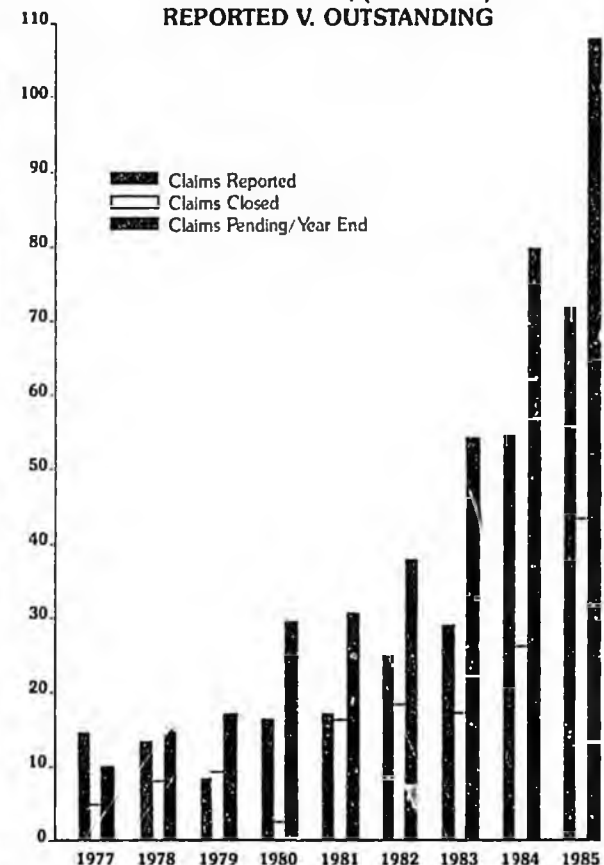
depth review of the factual situation with the policyholder, and to consolidate all of the available medical records on the case. This initial information and documentation is provided to one or more physicians of the same medical specialty as our insured, for an opinion on whether the facts indicate the standard of care was met under the circumstances. This initial investigation and peer review opinion provides a swift and solid foundation upon which the defense of the case can be built. Conversely, it can also provide the basis for prompt settlement if the facts prove the claim to be meritorious.

MICA's unique ability to respond to the urgent needs of our policyholders when a real or potential claim arises, cannot be overemphasized. Our claims staff knows Alaska, they know our physicians, they know our entire health care provider community, and most importantly, MICA is recognized as the dominant writer of medical malpractice insurance in Alaska that will vigorously resist the demands of its adversaries all the way to the jury, if necessary, on frivolous and non-meritorious claims.

TOTAL NUMBER REPORTED CLAIMS, (1977-1985)



CASE SUMMARY, (1977-1985) REPORTED V. OUTSTANDING



RISK MANAGEMENT

Risk Management at MICA had its real beginning in December 1983 with the hiring of Janet Johnston, R.N., M.S.N., as the MICA staff person charged with the responsibilities of investigation/resolution of claims along with the institution of a Risk Management program. Ms. Johnston's experience in clinical nursing and as a nursing administrator and consultant, was further augmented by MICA's exclusive Alaska contract with Dr. Robert Brittain of Denver, Colorado, a nationally recognized pioneer and leader in the field of medical malpractice Risk Management. In 1984, MICA's Risk Management Committee was formed, bringing together seven physicians from the Alaskan medical community, each recognized as a leader in his or her field of medical practice. Three other physicians have since joined the Committee, and several others have been asked to serve from time to time to meet special needs and to provide special expertise to the Committee and the Risk Management program.

The initial thrust of the Risk Management Committee was to begin educating itself by reviewing past as well as new claims in an attempt to delineate those risk management factors which were involved. In addition, the members of the Risk Management Committee were able to meet with and to review their efforts with Dr. Brittain.

Risk Management is primarily an educational venture, one of identifying those factors which are instrumental in either provoking or preventing claims and, once identified, of educating physicians as to those factors and as to the means of either countering them or

using them to provide a viable defense. To this end, the Risk Management Committee has been involved in the following:

1. Seminars, utilizing both medical and legal personnel: in one instance to speak to relevant Risk Management issues as viewed from both the plaintiff's and defendant's side of the issue and in another, to discuss the proper management of the litigation process itself from the physician's standpoint.
2. Individual presentations to the medical and nursing staffs of our insured hospitals, using the services of Ms. Johnston and one or more members of the Risk Management

Committee.

3. Circulation of a growing library of videotapes of the seminars and of tapes made for MICA by Dr. Brittain on specific topics of Risk Management importance.
4. MICA Risk Management Bulletins featuring articles on Risk Management written by Ms. Johnston and members of the Risk Management Committee or reprinted from other Risk Management periodicals published by the insurance industry.

Unfortunately, the principle of "tell 'em, tell 'em again, then tell 'em what you told 'em," though valid in concept,

is just not enough!

Recently, the MICA Board of Governors' Chairman wondered aloud as to whether the Risk Management program was reaching the point of diminishing returns. While it is premature to attempt to judge the effects of a risk management program (barely 21 months old), claims continue to occur, often as the direct result of the failure to observe basic risk management principles, while other claims prove indefensible in the face of good medicine for the very same reasons.

While no claim is the sole result of a single factor, it is estimated that in excess of 40% of the claims presently



UNDERWRITING

Determining adequate premium levels as well as establishing and maintaining criteria for insurability are the key functions of the Underwriting Department and they form the financial foundation upon which a fiscally sound insurance company is built.

Each year MICA carefully analyzes the balance between its income derived from earned premiums (and secondarily from investment return) as opposed to both actual and anticipated expenditures. These include: claims settlements, reinsurance costs, plus normal operating expenses in addition to incurred liabilities in reserving the estimated costs of pending claims.

In 1985, MICA's expenditures exceeded income from all sources, and policyholder surplus was utilized to offset this deficiency. The other alternative would have been to implement mid-term premium increases which the MICA Board of Governors rejected in favor of subsidizing MICA's policyholders' rates through the use of surplus.

At the close of 1985 it was apparent that premium increases were required to correct the imbalance of expenditures and incurred liabilities exceeding income. Additionally, a sufficient amount of income would have to be generated in the future to replenish policyholder surplus which acts as a financial cushion to absorb unexpected and catastrophic claims experience or other unanticipated expenses.

MICA's rate levels are not arbitrar-

ily created by the company. The fact is, that domestic insurance carriers, such as MICA, are one of the most highly regulated industries in the United States.

All rate increases must first be supported by actuarially sound documentation and then reviewed by the MICA Board of governors. The rates are then filed with the Alaska Division of Insurance for approval by the Director who can reject the filing if he determines that the rates are excessive or inadequate. Thus, rate increases must be fully supported by a need and thoroughly evaluated by the MICA staff and the MICA Board of Governors, as well as approved by the state regulatory agency before they are implemented.

MICA's underwriting guidelines were created to provide an equitable and uniform basis upon which to determine insurability. Careful underwriting is the method utilized to control the cost of insurance for the majority of our policyholders who present a normal exposure to loss. Conversely, prudent underwriting would mandate rejecting an application by a particular physician who most likely would cause other policyholders to support, to an unfair degree, that physician's claims costs.

Ultimately, the beneficiary of prudent underwriting is the physician who is professionally qualified, without a history of medical misadventures. Proper underwriting often involves very painful decisions which are taken very seriously by the MICA staff and your Board of Governors. However,

without underwriting criteria, the financial integrity of the corporation would clearly be impaired which patently would not serve the best long term interests of the corporation or our policyholders.

INVESTMENTS

Despite declining interest rates and a larger portion of its portfolio in short-term investments, MICA's net investment income reached \$1,158,000 in 1985, exceeding the 1984 figure by more than \$59,000. This increased income was attributable entirely to a 10% increase in earning assets. Additionally, with the decline in market interest rates, MICA's portfolio of notes and bonds increased in market value. At year's end, that market value exceeded by more than \$500,000 the value shown on the company's books.

MICA is entering 1986 in a very liquid position. This reflects recognition by its board of governors of the uncertainties facing the liability insurance business in the present environment, including the cost and terms of reinsurance. Nonetheless, our basic investment policy continues to emphasize high asset quality and stable returns. In 1986, as in the past, MICA's investment income will be an important and dependable supplement to its income from policyholder premiums.

ASSET COMPOSITION

	<u>Cost</u>	<u>% of Assets</u>	<u>Yield On Cost</u>
Cash Equivalents	\$1,123,816	11.4%	7.63%
U.S. Treasury Notes	4,919,412	50.1	11.34
Federal Agency Obligations	1,113,563	11.3	10.77
Corporate Obligations & Canadian Yankee Issues	<u>2,670,618</u>	<u>27.2</u>	<u>11.52</u>
Total Assets	\$9,827,409	100.0%	10.90%

MATURITY

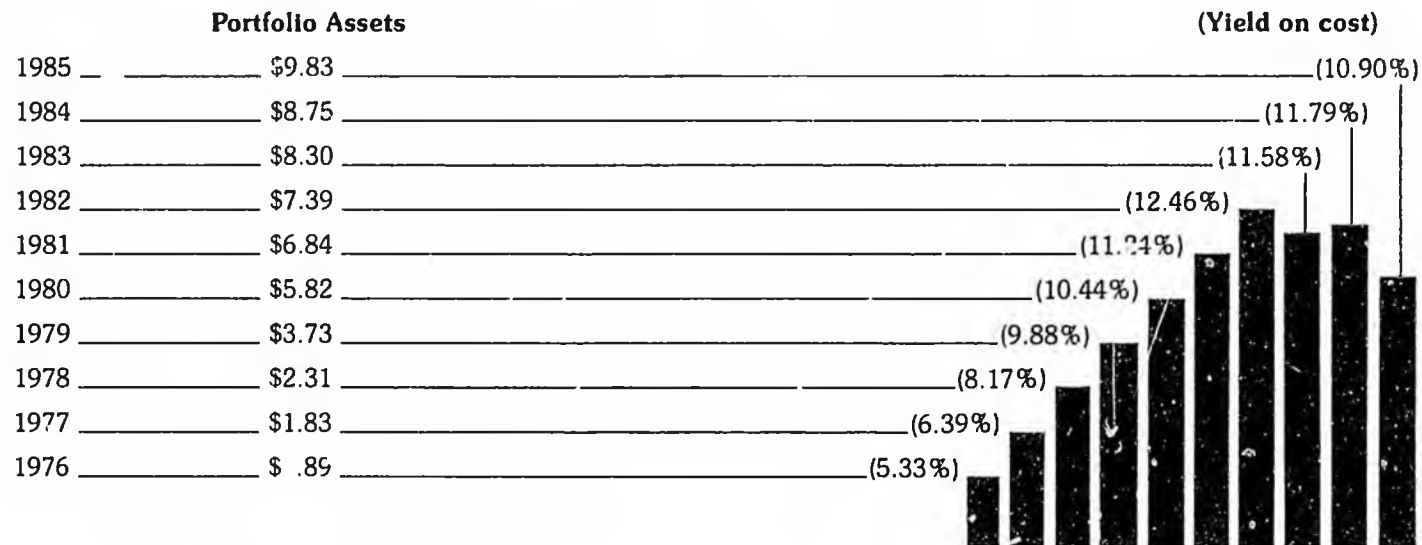
	<u>Cost</u>	<u>% of Assets</u>	<u>Yield On Cost</u>
Immediate Liquidity	\$1,123,816	11.4%	7.63%
1986	735,510	7.5	10.93
1987	1,049,203	10.7	9.09
1988	740,344	7.5	11.37
1989	594,472	7.1	10.63
1990	698,828	7.1	12.07
1991	725,203	7.4	13.49
1992	755,375	7.7	11.43
1993	980,398	10.0	11.82
1994	927,344	9.4	12.76
1995	<u>960,969</u>	<u>9.8</u>	<u>10.60</u>
Subtotal	\$9,391,462	95.6%	10.90%
	<u>435,947*</u>	<u>4.4</u>	<u>10.75</u>
Total Assets	\$9,827,409	100.0%	10.90%

* Segregated assets held to fund long-term liability

INVESTMENTS

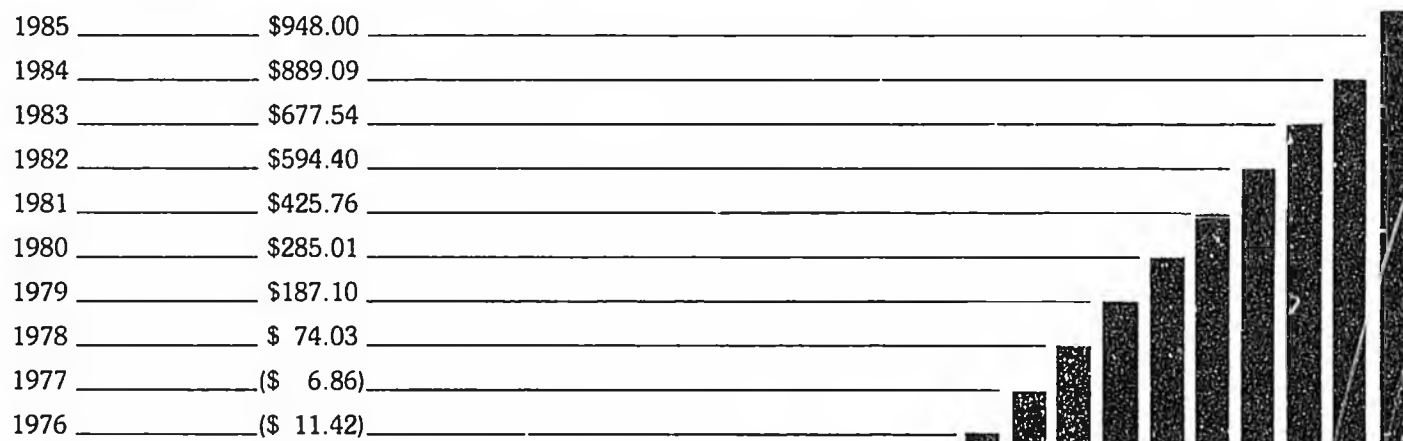
Investment Yield (Portfolio Assets)

\$ Figures for funds invested represented in millions



Net Investment Gain—(Investment income less interest expense for State of Alaska loan)

\$ Figures for net investment gain represented in thousands



FINANCIAL STATEMENTS

Medical Indemnity Corporation of Alaska

Ernst & Whinney

Board of Governors
Medical Indemnity Corporation of Alaska
Anchorage, Alaska

We have examined the balance sheets of Medical Indemnity Corporation of Alaska (MICA) as of December 31, 1985 and 1984, and the related statements of operations and changes in policyholders' surplus (deficit) and changes in financial position for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

As more fully described in Note B to the financial statements, the reserve for unpaid losses and loss adjustment expenses was determined based upon an estimate of the ultimate settlement costs of all losses and loss adjustment expenses. Management believes that the reserve for unpaid losses and loss adjustment expenses is adequate. However, no assurance can be given that the ultimate settlements will not be significantly greater or less than such estimated amounts included in the Corporation's financial statements.

In our opinion, subject to the effects on the financial statements of such adjustments, if any, as might have been required had the outcome of the uncertainty referred to in the preceding paragraph been known, the financial statements referred to above present fairly the financial position of Medical Indemnity Corporation of Alaska at December 31, 1985 and 1984, and the results of its operations and the changes in its financial position for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Ernst & Whinney

Anchorage, Alaska
February 28, 1986

FINANCIAL STATEMENTS

Medical Indemnity Corporation of Alaska

BALANCE SHEETS

December 31

	1985	1984
ASSETS		
Investments—Note C:		
U.S. government notes and bonds—designated for retirement of note payable.....	\$ 606,354	\$ 546,356
U.S. government notes and bonds—undesignated	5,658,313	5,228,156
Canadian government bonds	247,422	246,875
Corporate notes	2,458,178	2,820,288
Short-term demand notes and money market investments	<u>1,113,191</u>	<u>133,699</u>
	10,083,458	8,975,374
Cash	108,953	131,427
Premiums receivable, less allowance for doubtful accounts of \$2,000 in 1985 and 1984	21,298	37,769
Accrued interest receivable	229,036	233,126
Note receivable	22,884	23,184
Account receivable—U.S. government		200,000
Computer equipment, less accumulated depreciation of \$7,418 in 1985 and \$3,548 in 1984	<u>11,933</u>	<u>15,803</u>
	<u>\$10,477,562</u>	<u>\$9,616,683</u>
LIABILITIES AND POLICYHOLDERS' SURPLUS		
LIABILITIES		
Unpaid losses and loss adjustment expenses	\$ 6,543,938	\$3,674,773
Deferred premiums—MCM policies		284,000
Deferred premiums—MCM policies—to be refunded	694,416	
Accounts payable and accrued expenses	143,262	150,037
Premiums received in advance	139,075	71,174
Liability to reinsurers	<u>62,000</u>	<u>401,162</u>
	7,582,691	4,581,146
NOTE PAYABLE TO STATE OF ALASKA	3,000,00	3,000,000
POLICYHOLDERS' SURPLUS (DEFICIT)	<u>(105,129)</u>	<u>2,035,537</u>
	<u>\$10,477,562</u>	<u>\$9,616,683</u>

STATEMENTS OF OPERATIONS AND CHANGES IN POLICYHOLDERS' SURPLUS

	Year Ended December 31	
	1985	1984
Revenue:		
Premiums earned:		
Physicians	\$2,510,344	\$1,869,421
Hospitals	679,858	714,567
Related health care	<u>141,219</u>	<u>109,067</u>
	3,331,421	2,693,055
Deduct (add):		
Reinsurance ceded	897,183	1,119,692
Change in deferred premiums	<u>410,416</u>	<u>(82,000)</u>
	2,023,822	1,655,363
Interest earned, less investment expenses of \$53,754 in 1985 and \$50,458 in 1984	1,158,190	1,099,093
TOTAL REVENUE	3,182,012	2,754,456
Losses and expenses:		
Losses and loss adjustment expenses	4,587,236	2,232,720
Other underwriting expenses—Note F	525,442	411,811
Interest expense on note payable to State of Alaska—Note E	210,000	210,000
TOTAL LOSSES AND EXPENSES	<u>5,322,678</u>	<u>2,854,531</u>
NET LOSS	(2,140,666)	(100,075)
Policyholders' surplus at beginning of year	2,035,537	2,135,612
POLICYHOLDERS' SURPLUS (DEFICIT) AT END OF YEAR	<u>\$ (105,129)</u>	<u>\$2,035,537</u>

See notes to financial statements

FINANCIAL STATEMENTS

Medical Indemnity Corporation of Alaska

STATEMENTS OF CHANGES

	Year Ended December 31	
	<u>1985</u>	<u>1984</u>
FUNDS PROVIDED		
From operations:		
Net loss	\$(2,140,666)	\$ (100,075)
Add (deduct) items not affecting cash:		
Increase in liabilities	3,001,545	834,933
Decrease (increase) in premiums receivable	16,471	(19,807)
Decrease (increase) in accrued interest receivable	4,090	(34,282)
Decrease (increase) in notes and accounts receivable	200,300	(167,618)
Purchase of computer		(19,351)
Amortization of bond discount	(109,857)	(88,075)
Depreciation of computer equipment	<u>3,870</u>	<u>3,548</u>
FUNDS PROVIDED FROM OPERATIONS	975,753	409,273
Maturity of investments	<u>2,000,000</u>	<u>1,065,000</u>
TOTAL FUNDS PROVIDED	2,975,753	1,474,273
FUNDS USED		
Purchase of investments	3,018,735	1,508,972
DECREASE IN CASH	(42,982)	(34,699)
Cash and money market investments at beginning of year	<u>265,126</u>	<u>299,825</u>
CASH AND MONEY MARKET INVESTMENTS AT END OF YEAR	<u>\$ 222,144</u>	<u>\$ 265,126</u>

See notes to financial statements

NOTES TO FINANCIAL STATEMENTS

MEDICAL INDEMNITY CORPORATION OF ALASKA

December 31, 1985

NOTE A—ORGANIZATION AND OPERATIONS

Medical Indemnity Corporation of Alaska (MICA) is an insurance company created by the Alaska legislature to provide professional liability insurance to Alaskan physicians and surgeons, hospitals, and related health care organizations. MICA commenced business on June 28, 1976.

The daily operations of MICA are managed by an independent consulting firm, which is compensated on the basis of actual costs plus a management fee.

Prior to January 1, 1979, MICA issued "occurrence" basis policies which provide coverage for the policyholder for claims incurred during the policy year regardless of when the claims are reported to MICA. Since January 1, 1979, MICA has issued only "claims-made" policies which provide coverage for the policyholder for claims reported during the policy year to MICA, regardless of when the claims were incurred. Until December 31, 1985, MICA also issued a "modified claims-made" policy ("MCM") which provides coverage for the policyholder for claims reported during the first twelve months subsequent to the policy expiration date and also for claims reported during the policy year.

MICA also offers policyholders who terminate their policy the option of purchasing a "tail" (occurrence) policy which will indemnify the policyholder against future claims that occurred while a MICA policyholder.

MICA was capitalized with a note payable to the State of Alaska.

NOTE B—SIGNIFICANT ACCOUNTING POLICIES

Basis of Presentation: The accompanying financial statements have been prepared in conformity with generally accepted accounting principles which are not significantly different from accounting practices required for statutory purposes. Anticipated investment income is considered in determining if premium deficiencies exist.

Premiums: Premiums are earned ratably over the policy period to which they apply. Policies are written on a calendar year basis.

Deferred Premiums (to be refunded): Deferred premiums to be refunded are the result of discontinuing the sale of MCM policies. MICA will refund a premium to MCM policyholders at December 31, 1985 based upon the number of years the policyholder has been with MICA.

Underwriting Expenses: Underwriting costs are expensed when incurred. Due to the nature of MICA's operations, commissions and premium taxes are not significant.

Losses and Loss Adjustment Expenses: The liability for unpaid losses and loss adjustment expenses represents an estimate of the ultimate net cost of all such amounts unpaid at the balance sheet dates. The liability has been determined using case basis evaluations and statistical analyses and projections. The statistical analyses and projections have been determined by independent consulting actuaries using MICA's own historical loss data, giving effect to estimates of trends in claim frequency and severity, and are inherent in MICA's premium structure. These estimated liabilities are continually reviewed and, as adjustments become necessary, such adjustments are reflected in current operations. Although MICA believes the estimate for the liability is reasonable under the circumstances, MICA's actual incurred losses and loss adjustment expenses may vary from the amounts included in the financial statements.

Depreciation: Computer equipment is recorded at cost and depreciated over the estimated useful life of the assets using the straight-line method.

NOTE C—INVESTMENTS

Investments in government and corporate notes and bonds are carried at amortized cost. The market values of these investments were as follows:

	December 31	
	1985	1984
U.S. government notes and bonds	\$6,620,891	\$5,740,791
Canadian government bonds	290,625	260,938
Corporate notes	2,598,776	2,908,001

Short-term investments are carried at cost, which approximates market value.

Notes with an amortized cost of approximately \$400,000 were pledged to the Alaska Insurance Department to meet statutory requirements.

The Board of Governors has designated U.S. government notes and bonds with an amortized cost of \$606,354 in 1985 and \$546,356 in 1984 for retirement of the note payable to the State of Alaska.

Realized gains and losses, which are not material to the financial statements, are determined on the basis of specific identification and are included in interest income for presentation purposes.

NOTE D—REINSURANCE

Loss and loss adjustment expenses incurred during 1985 for claims in excess of \$250,000 up to \$2,000,000 per occurrence are 83.5% recoverable under excess of loss reinsurance contracts. MICA remains liable for the 16.5% of excess loss not covered by reinsurance. Additionally, MICA has a deductible of \$831,000 for excess losses under their reinsurance agreements for 1985 claims.

Loss and loss adjustment expenses incurred during 1984 and prior years in excess of \$200,000 up to \$5,000,000 per occurrence are 100% covered by reinsurance agreements.

MICA would remain liable to the extent reinsurance companies are unable to meet their obligations.

Amounts which have been deducted from liability, income, and expense accounts in connection with all ceded reinsurance placed with other companies are as follows:

	1985	1984
Estimated losses and loss adjustment expense to be recovered from reinsurer	\$3,090,000	\$1,775,000
Reinsurance premiums incurred	897,183	1,115,692
Losses paid by reinsurer	1,023,149	546,994
Loss adjustment expenses paid by reinsurer	34,663	6,241

NOTE E—NOTE PAYABLE TO THE STATE OF ALASKA

The Act which created MICA provided for its initial capitalization through a loan of \$3,000,000 from the Medical Malpractice Revolving Loan Fund of the State of Alaska. This loan, which may not exceed \$6,000,000, is subordinated to all other obligations of MICA. The remaining \$3,000,000 available under this provision from the State can be drawn on if operations demand.

Repayment of the loan is to be made in installments based upon underwriting earnings computed as specified in the Act. No repayment was due at December 31, 1985 or 1984. Interest at 7% is payable quarterly.

The remaining \$3,000,000 of the available loan from the Medical Malpractice Revolving Loan Fund requires repayment within five years from the date MICA receives the additional funds. Interest on the additional funds is payable at six percent.

NOTE F—MANAGEMENT AGREEMENT

MICA's daily operations are managed by Marsh & McLennan, Inc. on the basis of cost reimbursement plus a management fee.

NOTE G—INCOME TAXES

MICA has received a ruling from the State of Alaska and a professional opinion that as a public corporation created by the State of Alaska, it is exempt from income taxes.

NOTE H—COMMITMENTS

MICA leases office space with an annual rental expense of approximately \$27,000 through December 1985. Rental expense was \$27,000 in 1985 and 1984. MICA has renewed its present lease through December 1986.

1985 Medical Malpractice Update

By: Roger F. Holmes, Esq.

1984 was the worst year in the history of the property/casualty insurance industry. In the wake of the 1984 experience, 1985 resulted in the most violent market constriction in the history of the insurance industry. In 1985 underwriting losses continued to mount. 16% of the United States insurance industry is targeted for observation of financial problems and possible insolvencies under an industrywide early warning system.

Between 1975 and 1985 the medical malpractice field as a whole failed to turn an underwriting profit in every year except 1977. Medical malpractice premiums nationwide in 1985 rose an average of 32%. In New York, premiums for all physicians rose an average of 52%. The predictions are for similar rate increases in 1986. Lloyds of London, a substantial medical malpractice underwriter, has threatened to pull out of the United States market completely.

The New Mexico medical malpractice insurance captive which was providing insurance for Wyoming physicians pulled completely out of the State of Wyoming. In Illinois, the average jury verdict against health care providers doubled and the percentage of defense verdicts in medical malpractice cases dropped below 70% for the first time ever to 57.6%. The average jury verdict in medical malpractice cases ten years ago was \$166,000. That average has now reached \$955,000. At least 16% of all physicians nationwide are being sued each year. Of 75 perinatology programs in the United States, 45 now have vacancies. Many attribute this largely to the malpractice climate.

In the face of these dismal statistics, the push for tort reform in the '80s has

become very strong. Physicians in many states have engaged in slowdowns or otherwise refused to perform surgery in an effort to dramatize this situation. It has been estimated that if meaningful tort reform takes place in the medical malpractice field, a billion dollars a year can be saved.

In 1985 Illinois adopted a comprehensive medical malpractice tort reform package. Within very few months, a trial judge struck the entire scheme down as unconstitutional. Similarly in Louisiana and Texas portions of medical malpractice reform legislation were struck down as unconstitutional.

Conversely, the United States Supreme Court affirmed without opinion several decisions from the California Supreme Court upholding various medical malpractice reforms. What sets the 1986 tort reform movement apart from earlier movements is that many of the proposals are not limited to the medical malpractice field. This should give those reforms which are passed a much greater chance of standing constitutional scrutiny.

One short term problem with tort reform can be seen from the 1985 Illinois experience. Prior to the adoption of the medical malpractice reform, 9 to 10 medical malpractice cases were filed a day in Chicago. In the three days before the effective date of the statute, over 1,250 medical malpractice claims were filed in the City of Chicago with 725 of those suits alone being filed in the afternoon prior to the effective date of the statute. Lawyers and their staff members were standing 50 deep in six or more lines waiting to file medical malpractice cases that afternoon in order to have those cases filed before the effective date of the

reform legislation and thus be governed by the prior rules.

The focus of medical malpractice suits continues to center on the hospitals. One very good reason for this is that 80% of all medical malpractice claims arise from events occurring inside the hospital. One favorite attempt by plaintiffs is to try and hold the hospital liable under the doctrine of ostensible agency for emergency room doctors, pathologists, radiologists and other medical specialists whose practice is limited solely to the hospital. The courts are also beginning to hold hospitals strictly liable for injuries which result when equipment fails in the hospital setting resulting in injury to a patient.

An Arizona hospital stabilized an emergency room patient and instead of operating, transferred the patient to a public hospital for surgery. The reason for the transfer was because the patient did not satisfy the hospital's financial requirements for admission. The Arizona Supreme Court held that licensed hospitals were required to accept and render emergency care to all patients who presented in need of such care. The court held that the hospital could not transfer the patient until all medically indicated emergency procedures were completed without consideration of the economic consequences.

Hospitals are now taking a close look at the safety of their parking lots. They are being sued by employees, doctors, patients and visitors not only for defective conditions such as potholes, ice and snow, etc., but also for criminal attacks outside of the hospital but on hospital premises.

Several cases litigated in 1985 in-

volved the patient's refusal to accept blood. In Washington, a Jehovah's Witness refused before a D&C to consent to any blood transfusion if the need arose. The patient signed a waiver form. The court found that this waiver form did not protect the hospital or the doctor where the plaintiff bled to death as a result of negligence during the procedure. The court found that the patient had accepted the risk of no blood, but had not accepted the risk of medical negligence. At least one state supreme court found that a competent adult patient can refuse blood even though it is life threatening. However, where the patient is unconscious courts have ordered the transfusion over the objection of the patient's family. Courts have also ordered transfusion of children over the objections of their parents.

One of the most difficult areas facing hospitals in 1985 involved acquired immunodeficiency syndrome otherwise known as AIDS. The problems facing the hospital involved the emergency room, elective admissions, employee relations, whether to require AIDS screening and if so what to do with positive results. Questions have arisen as to whether or not doctors afflicted with AIDS should be allowed to operate and whether employees with AIDS should be allowed to be involved in patient care.

The consensus seems to be that it is negligent for any blood donation center or hospital not to test blood for AIDS contamination. People who are at risk are being asked not to donate. Since the results of AIDS tests in many instances must be reported to governmental agencies, the blood centers and hospitals now need detailed consent forms from the

donors acknowledging they understand that these results will be so reported.

Psychiatrists have been held liable for injuries inflicted by one of their patients on a third person when they knew that person to be at risk. A similar concern has arisen in the AIDS situation. The question has arisen whether or not there is a duty to warn others who might be at risk from the patient's AIDS condition especially where the patient is a sexually active person. For instance, must the spouse be warned.

AIDS concerns have arisen with the sperm banks. Patients are presenting in hospitals wanting volunteer blood and asking not to be transfused from the general pool. Hospitals which are self insuring all or a portion of their employees' health plan costs are faced with difficult decisions on what screening must be done since the average cost to treat an AIDS patient in 1985 has risen to \$142,000. Doctors and hospitals are faced with being sued a substantial number of years in the future in AIDS related cases because of the long incubation period and the fact that the statute of limitation runs two years from the date of discovery.

At least one case arose in which a hospital nurse sued the admitting physician for not warning her and other nurses that the patient was an AIDS victim. The nurse inadvertently broke the skin on her hand with a needle after giving an injection to the patient.

The hospitals continue to be plagued by lawsuits arising out of the granting or denying of staff privileges. One supreme court held that a hospital may deny staff

privileges. One supreme court held that a hospital may deny staff privileges solely based upon the physician's inability to work with other physicians on the staff. Another supreme court continued the trend of holding that a hospital may revoke staff privileges or deny them for the failure to maintain liability insurance.

California held there was no duty by a proctor to a patient. The proctor was asked by the hospital to oversee the operation by a surgeon who was applying for staff privileges. In the course of that operation the surgeon made an error. The patient sued the surgeon and the proctor alleging that the proctor had an obligation to step in. The court found that the proctor owed no duty to the patient.

Lawsuits involving informed consent continued to make new law. Surgeons continued to be sued for failure to advise their patients of alternatives to surgery. The courts are holding that all major schools of thought need to be conveyed to the patient, not just those that the doctors believe to be the preferred school of thought. In California, a neurologist withheld the correct diagnosis from the patient. The testimony at trial was that it was the community standard to withhold diagnoses when in the clinical judgment of the physician it was necessary. There was no medical testimony to the contrary. The judge instructed the jury that the doctor had a fiduciary obligation to the patient to disclose all risks associated with medical treatment, including all material facts known to the physician regarding the patient's condition and diagnosis. The North Carolina Supreme Court reinforced this by stating that the informed consent requirement supercedes the "best interest rule." The North Carolina Supreme Court

ruled that a physician may have to disclose risks even if he determines disclosure is not in the patient's best interest.

Four states have recently ruled on the issue of emotional distress claims associated with medical malpractice incidents. Only Michigan has allowed these claims. The Michigan court allowed parents to sue for emotional distress arising from circumstances surrounding a still birth.

One physician was held liable for the failure to warn of the possibility of hemophilia prior to birth. The physician did not cause the condition but was sued for the additional medical costs involved in raising the child. The parents claimed they would have aborted the pregnancy had they had the information concerning the possible hemophilia. Illinois rejected the attempt to make a pharmacist liable for not warning the patient that the physician was overprescribing medication. A physician was found liable to the patient's heirs for wrongfully prescribing medication in excessive amounts when the patient was a known drug addict. The patient later committed suicide. Doctors are regularly being sued at the present time for failing to obtain an informed consent before prescribing medication.

In Michigan a doctor was held liable for the injuries sustained by a person in an automobile accident where the driver, an epileptic, was a patient of the physician. The plaintiff claimed that the doctor was negligent in failing to instruct the epileptic to either continue his medication or not to drive after withdrawing from the medication. In New York the court ruled as a matter of law that the prescription of a drug by a physician in an amount ex-

ceeding the dosage recommended by the manufacturer constituted evidence of a deviation from the proper standard of medical care.

In California the court resurrected the captain of the ship doctrine to hold the surgeon liable for the actions of a nurse employed by the hospital. The court held that the nurse was acting under the direction of the doctor at the time of the incident. Several doctors were sued for revealing the identity of mothers who gave up children for adoption. These claims involved a breach of confidentiality. A national jury verdict survey has shown that while plaintiffs recover a favorable jury verdict in only 29% of their cases against general surgeons, they obtain favorable recoveries in 45% of the cases against orthopedic surgeons.

Alaskans did not escape the national trends in 1985. Reported medical malpractice claims nearly doubled in 1985. The nationwide reluctance of reinsurers to get involved in the malpractice market resulted in increased rates and decreased policy limits for many Alaska physicians.

The Alaska Supreme Court ruled in 1985 that plaintiffs may begin discovery in malpractice cases prior to the report of the medical advisory panel even though the statute itself states that discovery must generally await the report of the panel. The court held that plaintiffs would generally be prejudiced if they were required to wait until the panel had issued its report unless the panel report is filed within eighty days of the date the health care provider files an answer to the complaint. In many instances the court has not even appointed a panel within eighty days.

In 1984 the Alaska Supreme court ruled that a health care provider may use a favorable expert panel report in support of a motion asking the court to dismiss the plaintiff's case before trial. Health care providers were able to successfully use that case several times in 1985 to force dismissals of malpractice actions when the plaintiff failed to come forward with expert medical testimony contradicting the panel report.

Two medical malpractice cases were tried in 1985 in the State of Alaska. One case was tried in Anchorage and another in Fairbanks. Both resulted in verdicts in favor of the health care providers. In one case, the health care provider was actually in jail at the time the case was tried.

The MICA board continue to require that all lawsuits be tried which are determined by MICA's physician consultants to be without merit. Nothing that has happened in the legal community either in Alaska, or in the United States as a whole, during the year 1985 should operate to force a change in that policy.

Roger F. Holmes is a veteran defense lawyer of 17 years in Alaska's courtrooms. Holmes specializes in trials and appeals with his partner, Burton C. Biss in the lawfirm of BISS & HOLMES, Anchorage

ACKNOWLEDGEMENTS

Legal Article Roger F. Holmes, Esq.
Investment Article William G. Brock
Risk Management
Article Frederick Hood, M.D.
General Editing
& Writing Arthur M. Stanford
Printer Northern Printing

Description of Coverage

- 0 deductible.
- Contract Term Maximum: \$250,000.
- Co-payment: Temporary Health Care pays 80% of the first \$5,000 of covered expenses, then 100% of reasonable and customary covered expenses up to the Contract Term Maximum. (You pay only 20% of the first \$5,000 of covered expenses.)

Covered Services

For each of the following covered services, after you meet the 20% co-payment on the first \$5,000 of covered expenses, the program pays 100% of reasonable and customary covered expenses for treatment and care of injury and illness.

- Inpatient Hospitalization including intensive and coronary care.
- Emergency Room Treatment.
- Outpatient Hospital Services.
- Surgeon/Physician Services.
- Emergency Ambulance Service.
- Home Health Care: Up to \$5,000 per contract term, including nursing and home health aide care.
- Inpatient Rehabilitative Care for up to 30 days following a continuous inpatient stay for treatment of an acute condition.
- Medical Supplies, Prosthetic Devices and Rental of Durable Medical Equipment.

Eligibility Requirements

The contract is designed to provide medical coverage on a temporary basis. It is available, upon application and approval by Blue Cross of Washington and Alaska, to you and your dependents who:

- Are under age 65 and will remain under age 65 for the length of the contract.
- Carry no other medical or hospital insurance.
- Are unmarried legal dependents (as defined by the IRS Tax Code) who are under the age of 19.
- Are U.S. citizens or permanent residents (and can supply alien registration numbers).
- Are residents of either Washington State or Alaska.
- Are not eligible for Medicare.
- Are not hospitalized at time of application.

When Coverage Begins

- The full subscription rate must be paid at the time of application. Once coverage is effective, the payment is non-refundable regardless of any change in the subscriber's situation. The payment will, however, be refunded in full if coverage is denied (for instance, if the applicant is clearly ineligible based on the information provided in the application).

If applying for a second contract before the end of the first contract, and if the application is approved, the effective date will be the next day after the first contract expires.

Renewability, Cancellability and Termination

Two consecutive contracts can be issued to an individual or family. Any conditions which occur or for which claims were incurred during the first contract term become preexisting conditions on the second issue. The contract is valid only for the term issued. Temporary health care does not apply toward continuation of coverage on Blue Cross of Washington and Alaska individual products.

Exclusions

Benefits are not available for:

- Preexisting conditions that occurred within two years prior to the effective date of the contract.
- Routine procedures including routine foot care and symptomatic complaints of the feet; orthotics; hospital admissions for testing and examinations or dental treatment; treatment for obesity; cosmetic services and supplies; Milieu therapy; counseling or training services; educational materials or services; services or supplies not accepted by the medical profession or which are experimental or investigative; reproductive and sexual disorders and defects; sex transformations; surgical sterilization or reversal of surgical sterilization; services or supplies not medically necessary even if court-ordered.
- Conditions resulting from war, armed invasion or aggression.
- Services or supplies not charged for; private room charges; personal charges billed by an institution; services rendered by a provider who ordinarily resides in the subscriber's home or is related by blood or marriage.

- Work-incurred injury or illness covered by Workers' Compensation or other occupational coverage.
- Outpatient laboratory and X-ray services except those necessitated by an accidental bodily injury which occurred and is treated during the term of this contract; drugs and medicines except those given and used during a covered inpatient hospital stay.
- Hearing aid services or supplies; vision care services or supplies; vision therapy; orthoptics or ple-optics; dental services and supplies; orthodontia; temporomandibular joint dysfunction and myofascial pain-dysfunction; upper and lower jaw augmentation or reduction procedures.
- Services or supplies payable under the terms of any insurance policy issued to or on behalf of the subscriber or eligible dependent which provides payments toward medical expenses without determination of liability for the injury, such as automobile no-fault or homeowner's policy.
- Services or supplies received after coverage terminates or before coverage begins.
- Services or supplies to treat alcoholism, drug addiction or a nervous or mental condition; chiropractic or obstetrical care; convalescent or custodial services; outpatient rehabilitative care; speech therapy.
- Treatment rendered and billed by a hospice or skilled nursing facility.
- Treatment rendered outside of the United States or Canada; care in a hospital owned or operated by a county, state or federal agency, except for a medical emergency or as required by federal law.
- Services or supplies related to an illness or injury caused by participation in a hazardous avocation; self-inflicted injuries or suicide.
- Removal of tonsils or adenoids; expenses incurred by or for the donor of an organ for transplant.



Blue Cross
of Washington and Alaska

XEROX TELECOPIER 295 : 2-3-87; 6:53 AM : 3622013 : 5076863762000 : # 2

SHORT TERM COVERAGE

MALE

RATES PER TERM OF COVERAGE

AGE \ TIME	30	60	90	120	180
UNDER 30	30	60	90	120	180
30-39	32	64	96	128	192
40-44	38	76	114	152	228
45-49	49	98	147	196	294
50-54	65	130	195	260	390
55-59	93	186	279	372	558
60-64	154	308	462	616	924

GORDON EVANS

FOR PICKUP

FEMALE

AGE \ TIME	30	60	90	120	180
UNDER 30	34	68	102	136	204
30-39	40	80	120	160	240
40-44	53	106	159	212	318
45-49	68	136	204	272	408
50-54	86	172	258	344	516
55-59	111	222	333	444	666
60-64	141	282	423	564	846

CHILD

AGE \ TIME	30	60	90	120	180
10-19(23)	15	30	45	60	90



GROUP CONVERSION PROGRAMS

**THREE SPECIAL PROGRAMS
FOR ENROLLEES LEAVING
A BLUE CROSS GROUP**

Blue Cross of Washington and Alaska is pleased to offer a choice of one of three group conversion programs to Subscribers and eligible dependents no longer eligible for coverage under a Blue Cross group program. One program is sure to meet your needs.

The benefits and rates of each group conversion program will be different from those under your prior group program.

There are several advantages to selecting a group conversion program:

- Enrollees who transfer directly from a Blue Cross group program will not be required to complete health statements.
- There are no additional waiting periods, if you have satisfied the waiting period requirement under the prior Blue Cross group program.
- There will be no denial of benefits based on any preexisting medical condition, provided the waiting periods (if any) were satisfied under the prior program. For more information, see "Waiting Period Requirements" on page 2.

FOR POSSIBLE COST SAVINGS

You may wish to consider application for enrollment under one of our Traditional or Prudent Buyer individual programs, (available to persons under age 65). These programs have deductible options of \$100, \$200, \$500 and \$1,000, and are available at a lower cost (in most cases) and furnish broader benefits than are available under the group conversion programs. Nonsmokers may be eligible for a discount of up to 10 percent on the individual programs. For details, contact our Customer Service Department at one of the numbers listed on the back of this brochure.

PLEASE NOTE: Enrollment under the individual programs is subject to compliance with medical underwriting requirements. This means you might not be accepted for coverage under an individual program. Should this occur, you still will be eligible for one of the group conversion programs provided you applied for an individual program within 31 days of the date coverage under your group program terminated. In addition, upon enrollment under one of the individual programs, certain waiting periods are applicable (unless you have had at least 24 consecutive months of continuous coverage under a Blue Cross group program immediately preceding your application for an individual program).

WHO IS ELIGIBLE

Enrollees eligible to apply for group conversion coverage are:

The Subscriber; the lawful spouse of the Subscriber; any child(ren) of either (or both) the Subscriber or spouse who is unmarried, under 23 years of age, and dependent upon the Subscriber for his or her main support and whom the Subscriber could claim as a dependent for tax purposes under the United States Internal Revenue Code.

APPLICATION FOR COVERAGE

Application for a group conversion program must be made within 31 days of the date coverage under your group program terminates. The Subscriber and/or eligible dependents who were covered on the prior group program and apply within 31 days of the date coverage under the group program terminates will not be required to complete health statements.

The following dependents may apply for coverage under the Subscriber's group conversion program by submitting a completed application and health statement. In such cases, Blue Cross of Washington and Alaska reserves the right to rider (disallow) coverage for specific medical conditions or deny coverage to a specific family member.

- Any eligible dependent who was not previously covered on the group program;
- Eligible dependents who did not enroll in a conversion program within the stated 31-day period;
- Natural newborn children not added to a conversion program within 60 days of birth;
- Adopted children not placed with the Subscriber within 60 days of birth;
- Adopted newborn children who are placed with the Subscriber within 60 days of birth, but are not added to a conversion program within 60 days of placement; and
- Other newly acquired eligible dependents (e.g., as through marriage).

If a covered dependent becomes ineligible because of marriage or attaining age 23, he or she may transfer to his or her own group conversion program. Application must be made within 31 days of a change in status.

Once enrolled in one of the group conversion programs, there will not be an opportunity to change programs, except as specified above.

WHEN BENEFITS BEGIN

Subject to the 31-day application requirement (see "Application for Coverage" above), the effective date of coverage is the first of the month following the date your prior group program terminates, provided the required subscription charges have been paid. However, there may be waiting periods, if the waiting periods required under your previous group membership have not been satisfied (see "Waiting Period Requirements" below).

Coverage for a natural newborn child, born on or after the Subscriber's effective date, begins as of his or her date of birth, if the child is enrolled within 60 days after its birth. Coverage for an adopted newborn child, physically placed with the Subscriber within 60 days of birth, begins as of the date of placement, if enrolled within 60 days of that physical placement.

When eligible dependents are not enrolled within the stated time periods, coverage begins on the first of the month following approval by the Plan, provided the required subscription charges are paid. The waiting period requirements stated below will apply.

WAITING PERIOD REQUIREMENTS

Each group conversion program has a twelve-month "waiting period" before benefits begin for any preexisting condition. A preexisting condition is any illness, injury or condition, whether or not diagnosed, for which treatment, consultation or a diagnostic test was recommended or received by an Enrollee, or for which an Enrollee has taken prescribed or recommended medicines, or for which symptoms existed which would ordinarily cause an individual to seek medical diagnosis, care or treatment during the 12-month period prior to the effective date of his or her coverage.

Waiting periods may be waived entirely or the twelve-month period may be reduced under the following circumstances:

- If the prior Blue Cross group program did not have a waiting period, no waiting periods will be required under these group conversion programs, if enrolled within 31 days of the date prior group coverage ends.
- If the Enrollees prior Blue Cross program had a waiting period, any time the Enrollee was covered under that program will be credited to the waiting period requirements of the group conversion program.
- The waiting period of the group conversion program will not exceed the Enrollee's waiting period requirements of his/her prior group or conversion contract with the Plan.
- The waiting period will not apply to natural newborn children of the Subscriber enrolled within 60 days from birth, or to adopted newborns who are 60 days of age or less on the date of physical placement with the Subscriber, and are enrolled within 60 days of that placement.

CONVERSION CONTRACT MATERNITY BENEFITS

Conversion contract maternity benefits for the female Subscriber or male Subscriber's spouse are available when:

- Conception occurs while she is covered under the conversion contract and coverage is continuous from date of conception to date of delivery or other termination of pregnancy; or
- Conception occurs while she is covered under the prior group program that does not offer extended maternity benefits, required waiting periods are satisfied and coverage is continuous on the conversion program to date of delivery or other termination of pregnancy.

The maternity benefits of the prior group program for the female Subscriber or male Subscriber's spouse are available when:

- Conception occurs while she is covered under the prior group program (that does offer extended maternity benefits), required waiting periods are satisfied and coverage is continuous on the conversion program to date of delivery or other termination of pregnancy.

MAXIMUM MATERNITY BENEFITS UNDER GROUP CONVERSION PROGRAMS 040, 050 AND 060

Cesarean Section:		Normal Delivery:	
Physician	Up to \$300	Physician	Up to \$150
Hospital	Up to \$400	Hospital	Up to \$250

UTILIZATION MANAGEMENT

A preauthorization must be obtained for all hospital admissions (except for treatment of an injury within two days of the accident, medical emergencies and obstetrical delivery, however, we ask to be notified following an emergency admission to a hospital). Without preauthorization, benefits will be subject to a separate \$200 deductible and benefits may be denied or reduced if the services do not meet the Plan's criteria for medical necessity

EXCLUSIONS

We do not provide benefits for the following:

- Routine examinations, x-ray and laboratory testing; routine footcare and symptomatic complaints of the feet and orthotics; well baby care, including hospital infant nursery care; hospital admissions for diagnostic tests or evaluations.
- Conditions resulting from war, armed invasion or aggression.
- Private room or personal charges billed by an institution; and services rendered by a provider who ordinarily resides in the Subscriber's home or is related by blood or marriage.
- Work-incurred injuries or illness covered by Workers' Compensation or other occupational coverage.
- Treatment or surgery for obesity, including complications of surgery; and cosmetic services and supplies.
- Milieu therapy; counseling or training services; mental, neuropsychiatric or personality disorders; alcoholism, drug addiction or other substance abuse.
- Reproductive and sexual disorders and defects; sex transformations.
- Services and supplies not medically necessary, even if ordered by a court of law.
- Hearing aid services or supplies.
- Amounts over the reasonable and customary charge.
- Dental services and supplies, orthodontia, temporomandibular joint (T.M.J.) dysfunction and myofascial pain-dysfunction (M.P.D.); upper and lower jaw augmentation or reduction procedures.
- Chiropractic care.
- Hospice care; convalescent or custodial services; rehabilitative care.



**APPLICATION FOR
GROUP
CONVERSION PROGRAMS
040, 050 or 060**



Blue Cross
of Washington and Alaska

P.O. Box 327
Seattle, Washington 98111-0327

Application for Group Conversion Programs 040, 050 or 060

Please complete all items. Application will be returned if not completed in full. It must be signed by the applicant and spouse (if applying), parent or legal guardian (if the applicant is under 18 years of age). **PLEASE INCLUDE YOUR PAYMENT FOR THE FIRST TWO MONTHS. MAKE YOUR CHECK OR MONEY ORDER PAYABLE TO BLUE CROSS OF WASHINGTON AND ALASKA.** Thereafter, you may elect to pay monthly through the Automatic Bank Charge (ABC) system. Should your application be denied or withdrawn, your payment will be refunded in full. Application and payment must be received by _____/_____/_____ for acceptance.
Mo Day Yr

1. APPLICANT'S LAST NAME			FIRST NAME			INITIAL			2. SOCIAL SECURITY NUMBER											
MAILING ADDRESS									3. BLUE CROSS GROUP PLAN INFORMATION											
CITY									STATE			ZIP			Group Number			Subscriber ID #		
COUNTY									DATE COVERAGE ENDED											
TELEPHONE NUMBER — HOME ()						TELEPHONE NUMBER — WORK ()														

4. PAYMENT METHOD DESIRED						5. PROGRAM SELECTION					
<input type="checkbox"/> ABC Monthly Payment (If you check this box, we will send you an ABC Customer Agreement Form to complete after you are enrolled.) OR <input type="checkbox"/> Bimonthly payment						<input type="checkbox"/> Group Conversion Program 040 (\$1,000 Deductible) <input type="checkbox"/> Group Conversion Program 050 (\$5,000 Deductible) <input type="checkbox"/> Group Conversion Program 060 (\$500 Deductible)					

6. Complete the required information below for yourself and all eligible dependents you wish to enroll under the Group Conversion Program checked above. Please contact the Plan for additional applications, if you wish to enroll an eligible dependent under a different Group Conversion Program.

LAST NAME	FIRST NAME	MIDDLE INITIAL	SEX		BIRTHDATE			ON PRIOR COVERAGE		BLUE CROSS PLAN USE				
			M	F	MO	DAY	YR	YES	NO	O	E	D		
APPLICANT (a)														
SPOUSE (b)														
CHILD (c)														
CHILD (d)														
CHILD (e)														
CHILD(f)														

A. Are you or any dependents covered under any other group hospital or medical plan, government plan or Medicare? YES NO

1. If yes, state name of program and individuals covered _____

2. If on Medicare, is the person covered under Part A? YES NO

B. If the Blue Cross group plan which covered you and your dependents is terminating, are you or any dependents eligible to enroll in any other group hospital or medical plan, government plan or Medicare within 31 days of the Blue Cross group plan's termination? YES NO

1. If yes, state name of program and individuals covered _____

CONDITIONS OF ENROLLMENT

I apply for enrollment with Blue Cross of Washington and Alaska for myself and my eligible dependents listed. I understand that once enrolled in this program, there will not be an opportunity to change to one of the other conversion programs. I understand that a Health Statement must be completed and submitted for each dependent not previously covered on the Blue Cross Group Contract. Health Statements will be sent to me by Blue Cross of Washington and Alaska for all such eligible dependents listed on this application. I understand and agree that all statements and answers on this application are complete and true and that all rights to service are void if found false or incomplete. I understand that this Blue Cross Plan may rescind or modify my Contract retroactively if I omit material information on this application. I also understand and agree that coverage for dependents not previously covered on the Blue Cross Group Contract does not begin until this application is accepted by Blue Cross of Washington and Alaska and an effective date of coverage is assigned. I understand that receipt of my money (cash, check or money order) does not constitute enrollment under any conversion program. I also understand that if this application is accepted, it will become part of the Contract. I authorize Blue Cross of Washington and Alaska, at its option, to pay providers directly for services rendered.

Regarding dependents not previously covered on the Blue Cross Group Contract, I understand and agree that Blue Cross of Washington and Alaska may accept this application, but:

- 1. Restrict coverage for specific health conditions which existed prior to application for coverage; or
- 2. Totally exclude one or more dependents from enrollment.

Should this occur, the Subscriber will have an opportunity to review this information prior to enrollment.

* * * * *

I hereby authorize any physician, health care practitioner, hospital, clinic or other medical or medically-related facility to furnish Blue Cross of Washington and Alaska any and all records pertaining to medical history, services rendered or treatment given to anyone making application, enrolled hereunder, or added hereafter for purposes of review or investigation of a claim or for evaluation of an applicant or anyone added after the initial enrollment period, if applicable. This authorization shall become effective immediately and shall remain in effect as long as necessary to enable Blue Cross of Washington and Alaska to process the application and claims.

* * * * *

I, the undersigned, represent that:

- 1. I have read and personally completed all of the requested information on this form. (If not, please attach a letter of explanation.)
- 2. No material information pertaining to me has been withheld or omitted, nor any material information of any eligible dependent applying for this coverage.

* * * * *

I also understand that this Contract has a twelve-month waiting period, during which benefits are not available for any care or treatment of a preexisting condition (except for natural newborn children born on or after the Subscriber's effective date and enrolled within 60 days from date of birth and adopted newborn children physically placed with the Subscriber within 60 days of birth and enrolled within 60 days of that placement).

Waiting periods applied to enrollees covered under the prior Group Contract, who enroll during the initial enrollment period, will be credited to waiting periods required under this Contract. If there were no waiting periods under the prior Group Contract, no waiting periods will be required under this Contract. In any event, waiting periods required under this Contract will not exceed the Enrollee's waiting period requirements of the prior Group Contract.

Date _____ Signature of Applicant _____

Spouse's Signature (if applying) _____

Parent or Legal Guardian's Signature _____
(if applicant is under 18 years of age)

FOR BLUE CROSS PLAN USE ONLY											
GROUP NUMBER	EFFECTIVE DATE			C L	P 1	MONTHLY BILLING AMOUNT	MEMB COUNT	SHI	PAID TO DATE		
	MO	DAY	YR						MO	DAY	YR
BANK TRANSIT NO.		SUBSCRIBER ACCOUNT NO.				TYPE		DEBIT START DATE			
FORM SENT MO DAY YR	SENT BY: CA CS IS IUW				PAYMENT: PENDING NONE						

700-6711 (1-87)



Blue Cross
of Washington and Alaska

SEATTLE MAIN OFFICE
15700 Dayton Avenue North
P.O. Box 327
Seattle, Washington 98111-0327
(206) 367-1419
In Washington: 1-800-231-9519
(except Seattle)
Outside Washington: 1-800-257-9557

SPOKANE DISTRICT OFFICE
Washington Mutual Building
601 West Main / Suite 700
Spokane, Washington 99201-0613
(509) 838-0500

TACOMA DISTRICT OFFICE
6240 South Sprague
Tacoma, Washington 98409-6897
(206) 474-0719

YAKIMA DISTRICT OFFICE
707 North First Street / Suite A
Yakima, Washington 98901-2294
(509) 248-5267

ANCHORAGE DISTRICT OFFICE
3301 "C" Street
P.O. Box 102480
Anchorage, Alaska 99510-2480
(907) 561-5065
800-426-6400

- Services and supplies payable under the terms of any group hospital or medical program or Medicare.
- Services or supplies payable under the terms of any automobile medical, automobile no-fault, automobile uninsured motorist and/or underinsured motorist, personal injury protection (P.I.P.), commercial liability, homeowners policy or other similar type of insurance or contract which provides payments toward medical expenses without a determination of liability for the injury.
- Vision care services, supplies or procedures, including, but not limited to, eye exams, lenses, frames or radial keratotomy.
- Services, supplies or procedures not generally performed or accepted by the medical profession in the States of Washington and Alaska; any treatment, procedure, facility, equipment, drug, drug usage, device or supply which is considered experimental or investigative at the time rendered.
- Care in a nonparticipating or nonmember hospital owned or operated by a county, state or federal agency, except for a medical emergency or as otherwise required by law.
- Obstetrical care for dependent children, except for complications of pregnancy.
- Services or supplies received after coverage terminates.
- Services or supplies for which no charge would have been made if the contract were not in effect or for which the Enrollee is not legally liable.
- Drugs and medicines are not covered under Contract 040.

Some of these exclusions are subject to certain exceptions, which are described in the contract.

TERMINATION OF COVERAGE

Coverage terminates under the conversion contract when any one of the following circumstances occurs:

- For any Enrollee, when the conversion contract is terminated; on the date the Enrollee becomes eligible for Medicare; on the date the Enrollee has been provided with his or her lifetime maximum amount of benefits; when subscription charges are not received within the 10-day grace period following the due date.
- For the spouse, when he or she obtains a divorce or the marriage is otherwise terminated; when the Subscriber is no longer covered under this conversion contract (this includes death of the Subscriber).
- For dependent children, when they reach age 23 (unless they meet the requirements of an incapacitated child); marry; can no longer be claimed as a dependent by the Subscriber under the United States Internal Revenue Code; when the Subscriber is no longer covered under the conversion contract (this includes death of the Subscriber).

PAYMENT OPTIONS

Subscription charges may be paid on a monthly or bimonthly basis. Monthly payments can only be arranged through the ABC (Automatic Bank Charge) method. The ABC payment plan offers the advantage of monthly payments, withheld at no additional cost for the service, from your checking or savings account. If you choose to pay subscription charges on a bimonthly basis, you will receive a bimonthly billing by mail.

When returning your completed application to Blue Cross, attach a check or money order for the appropriate two-month payment.

If you desire the ABC method, you should:

- Verify with your bank that automatic transfer of funds can be electronically processed.
- Mark the box on the application that indicates you desire the ABC monthly payment method (see #4), and we will send you an ABC customer agreement form.
- Complete and sign the ABC customer agreement form.
- Attach a deposit slip from your checking or savings account.
- Coverage must be paid at least two months in advance of the time the ABC customer agreement form is received by us due to bank prenotification requirements. Subsequent payments will be automatically deducted.
- Retain the yellow copy of the ABC form for your files.

FOR ADDITIONAL INFORMATION ON OUR GROUP CONVERSION PROGRAMS,
CONTACT OUR CUSTOMER SERVICE DEPARTMENT:

In Seattle: 367-1419

In Washington: 1-800-231-9519 (except Seattle)

Outside of Washington: 1-800-257-9557

MONTHLY RATES

Program:	040	050	060
<u>Deductible Amounts:</u>	<u>\$1,000</u>	<u>\$5,000</u>	<u>\$500</u>
Subscriber	\$147.70	\$ 57.15	\$229.70
Subscriber & Spouse	212.35	82.15	330.20
Subscriber, Spouse & Child(ren)	267.60	103.50	416.15
Subscriber & Child(ren)	202.95	78.50	315.65





Blue Cross

of Washington and Alaska

SEATTLE MAIN OFFICE

15700 Dayton Avenue North

P.O. Box 327

Seattle, Washington 98111-0327

(206) 367-1419

In Washington: 1-800-231-9519

(except Seattle)

Outside Washington: 1-800-257-9557

SPOKANE DISTRICT OFFICE

Washington Mutual Building

601 West Main / Suite 700

Spokane, Washington 99201-0613

(509) 838-0500

TACOMA DISTRICT OFFICE

6240 South Sprague

Tacoma, Washington 98409-6897

(206) 474-0719

YAKIMA DISTRICT OFFICE

707 North First Street / Suite A

Yakima, Washington 98901-2294

(509) 248-5267

ANCHORAGE DISTRICT OFFICE

3301 "C" Street

P.O. Box 102480

Anchorage, Alaska 99510-2480

(907) 561-5065

800-426-6400



Retire With Confidence



Blue Cross
of Washington and Alaska

For People Covered by Medicare...

... Blue Cross of Washington and Alaska offers MedicarePlus, a choice of three plans to supplement your health care coverage. One is just right for you.

Why do you need more health care coverage?

Medicare provides comprehensive coverage, but it does **not** pay for **all** your hospital and medical expenses. For instance, under Medicare coverage the patient must pay:

- The first \$492 of hospital charges (known as the Part A "deductible");
- The remaining 20% of Medicare-approved Part B charges (Medicare pays 80%);
- Any amounts over and above the moderate level of charges allowed by Medicare.

Since the individual's share represents a significant financial responsibility, anyone covered by Medicare needs a supplemental plan to cover these out-of-pocket expenses.

Blue Cross has carefully designed three levels of MedicarePlus to give you a choice of supplemental plans. You can buy **as much** coverage as you need without buying **more** than you need.

Questions?

Call one of our toll-free numbers to receive an enrollment package. One of our MedicarePlus experts can further explain benefits or answer any other questions you may have about MedicarePlus.

In Seattle, call 367-1419

Other Washington cities, toll free (800) 231-9519

From Alaska, toll-free (800) 257-9557

30-Day Guarantee

We're so sure you'll be pleased with this new plan, we'll even give you 30 days from the date you receive your contract to thoroughly review your new coverage. If you're not completely satisfied, Blue Cross will fully refund your money.

Who's eligible?

Any resident of Washington and Alaska who is enrolled in Medicare Part A is eligible for MedicarePlus coverage. Enrollment in Medicare Part B also is required to apply for Medicare Plus I.

Here's how to make application

If you're interested in applying for Plus I, Plus II or Plus III, simply fill out the application. If you don't have one, we'll send you an enrollment package containing detailed benefit information and an application form. Each person desiring coverage must fill out a separate application, so if your spouse would like MedicarePlus coverage, be sure to request two packets.

A choice of payment plans, too

We can bill you every two months or monthly payments can be made through your bank. Payments for MedicarePlus can be automatically deducted from your checking, Transaction or savings account. An authorization card for automatic deduction is included in the enrollment package.

Terms of renewal or termination

MedicarePlus contracts are for two-month periods and are automatically renewed if subscription charges are paid on time. Your coverage may be terminated without notice if payment is not made within the 10-day grace period or if you drop Part A of Medicare.

Once you are covered by MedicarePlus, we will **not** terminate your contract due to a change in your health. You can cancel at any time by giving us at least 30 days' advance notice in writing.

Coverage is provided worldwide

Blue Cross of Washington and Alaska benefits are provided wherever you are in the world. For stays outside the country up to six months, we'll pay the Part A benefits Medicare would have paid, as well as our Part A and Part B supplemental benefits included in the MedicarePlus program you choose.

The following comparison of the three plans summarizes their features to help you decide which one best fits your needs.

All Three Plans pay the same supplement to Medicare Part A Benefits:

	Medicare Pays	MedicarePlus Pays	You Pay
HOSPITALIZATION			
First 60 days	All but \$492	\$492	Nothing for Medicare eligible services
61st to 90th day	All but \$123/day	\$123/day	
Lifetime Reserve (91st to 150th day)	All but \$246/day	\$246/day	
Beyond 150 days	Nothing	100% of UCR* charges up to 365 days lifetime limit	All other charges
HOSPICE CARE			
A hospice benefit period begins when a hospice plan of care is first elected and ends 14 days after such care is cancelled	The full cost of covered services for the terminal illness, EXCEPT: 5% of the cost for inpatient respite care and 5% (or \$5) of outpatient prescription drugs	100% of remaining Medicare-approved charges	Nothing
POST HOSPITAL SKILLED NURSING CARE			
First 20 days	100% of costs	Nothing	Nothing
21st to 100th day	All but \$61.50/day	\$61.50/day	Nothing
Each benefit period beyond 100 days	Nothing	Nothing	All charges

IN ADDITION, Medicare Part B Benefits are supplemented as follows:

	Medicare Pays	Plus I Pays	You Pay
Physician's Charges, Inpatient & Outpatient Medical Services, Supplies at a Hospital, Physical & Speech Therapy, Ambulance Charges	80% of approved charges after \$75 yearly deductible	\$75 yearly deductible plus 100% of UCR* charges not paid by Medicare	Nothing
		Plus II Pays Up to 20% of UCR* charges, including 20% of Part B deductible	All other charges
		Plus III Pays Up to 20% of UCR* charges AFTER \$200 deductible per year	\$75 Medicare deductible AND 20% of first \$625 UCR* charges each year AND all other charges

	Medicare Pays	Plus I Pays	You Pay
Routine Eye Exams	Nothing	Plus I Pays One exam every 24 consecutive months by participating provider paid in full (WA State only); exam from other providers up to \$45	All lens and frame charges AND all other charges
		Plus II Pays Same as Plus I	Same as above
		Plus III Pays Nothing	All charges
Hearing Exams	Nothing	Plus I Pays Up to \$70 for one routine exam every 24 consecutive months	Hearing aid costs AND all other charges
		Plus II Pays Nothing	All charges
		Plus III Pays Nothing	All charges
Outpatient Prescription Drugs	Nothing	Plus I Pays AFTER \$100 deductible, 50% of charges up to \$1500 for a total benefit of \$750 per calendar year	First \$100 AND 50% of next \$1500 AND all other charges
		Plus II Pays Nothing	All charges
		Plus III Pays Nothing	All charges

Our payment, when combined with Medicare's payment, will never exceed the total amount charged.

The vast majority of medical costs fall within Blue Cross of Washington and Alaska's usual customary and reasonable (UCR) allowance, which is determined by reviewing over four million claims every year. Because it's based on actual charges, our UCR provides greater reimbursement of your expenses than the usually lower Medicare payment levels.

Here's what MedicarePlus doesn't cover

- Anything excluded under the Medicare Act, unless otherwise specified. (Refer to **Your Medicare Handbook**, available from any Social Security Office, for a complete list of exclusions.)
- Private duty nursing; custodial nursing facility care costs or any other custodial care; intermediate nursing facility costs; or home health care expenses above the number of visits covered by Medicare.
- Drugs other than prescription drugs furnished

during a hospital, hospice or skilled nursing facility stay, except drugs covered under MedicarePlus I.

- Dental care or dentures; routine physical check-ups, routine immunizations; cosmetic surgery; routine footcare; routine eye and hearing examinations, hearing aids or eyeglasses, except as specified.
- Worldwide coverage beyond a six-month period.
- Services, procedures and supplies which would duplicate Medicare payments.

Rates

	MedicarePlus I	MedicarePlus II	MedicarePlus III
Under 65	Not Available	\$55.69	\$45.05
65-69	\$48.00	\$29.00	\$19.95
70-74	\$51.50	\$34.50	\$25.50
75-79	\$59.00	\$39.00	\$27.85
80+	\$71.00	\$46.00	\$29.75

Rates effective January 1, 1986 and are monthly rates for payments automatically deducted from your account.

For further details of coverage, including costs, exclusions, any reductions or limitations, and the terms of the contract, see your agent or call one of our toll-free numbers.

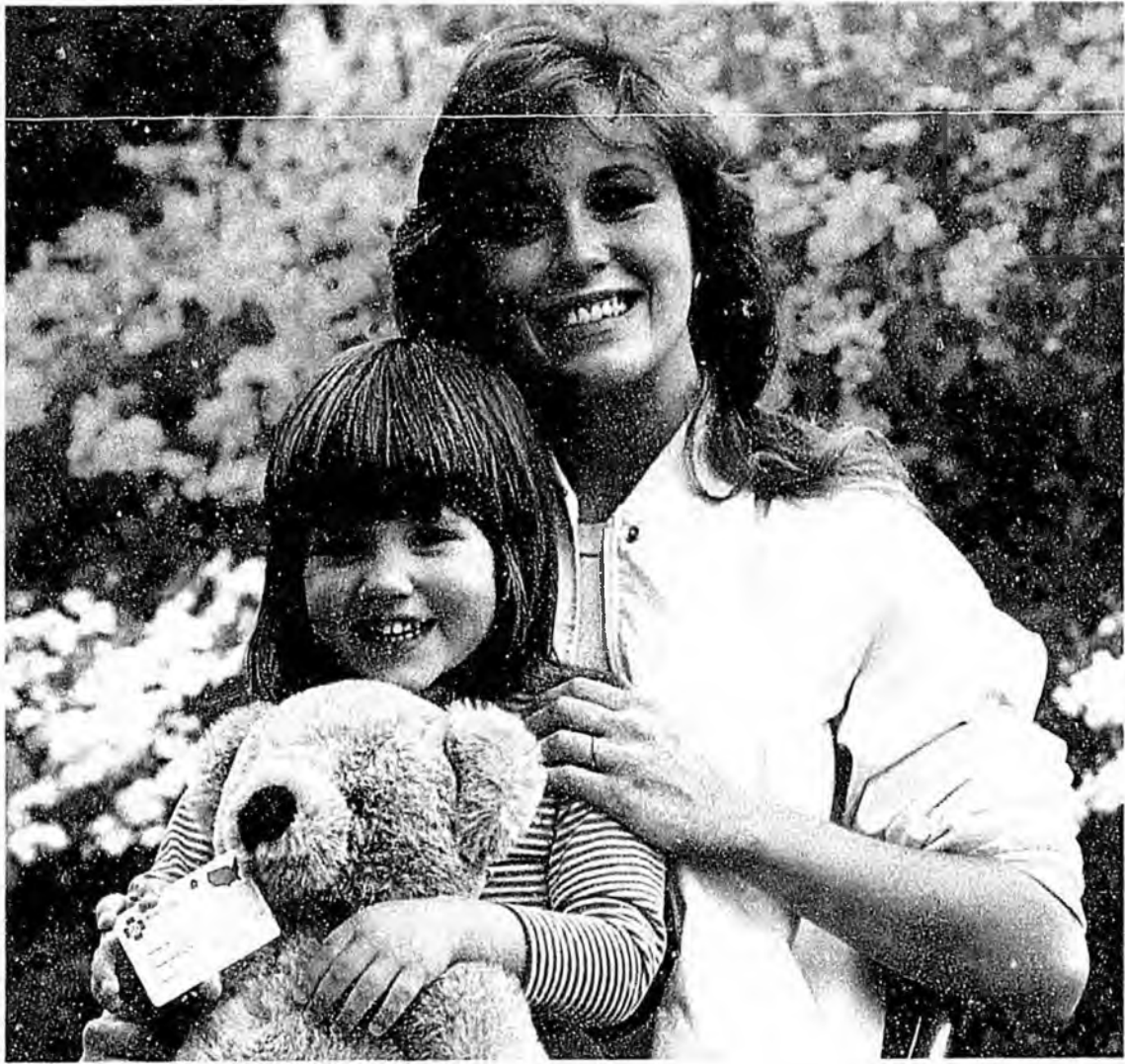




Blue Cross
of Washington and Alaska

We'll take care of it.

300-1445



With Our Plan,
You've Got Confidence



Blue Cross
of Washington and Alaska

THREE PROGRAMS, THREE RATES: ONE IS RIGHT FOR YOU

Three programs offering a choice of deductibles and three different rates. One of them is sure to meet your needs. And you can be confident of their quality because all three are from an organization you can trust.

With each of the programs you get \$1 million in coverage per member, and these advantages:

Worldwide Coverage — Your coverage is good around the world. And there's no need to reapply if you relocate anywhere within Washington and Alaska.

Choice of Physicians — You choose the physicians and specialists you want. You're not limited to one clinic or a list of doctors. No separate referral is required to consult with specialists.

Maternity Benefits — Maternity benefits are provided for you or your covered spouse without a separate deductible.

More Covered Services — Coverage is provided for chiropractic care, mental and nervous conditions, alcoholism, drug addiction, and prescription drugs in addition to medical and surgical benefits.

Nonsmoker Discount — If you and your covered spouse have been nonsmokers for at least one year, you qualify for a substantial discount of up to 10 percent.

Blue Ribbon — Our Finest Coverage

Our Blue Ribbon program has no deductible for hospital inpatient or selected outpatient services. The paid-in-full coverage extends to skilled nursing facilities, home health care and minor surgery on an outpatient basis. Please see the Benefits Summary for full details.

A \$200 yearly deductible per individual, limited to \$600 per family, applies to other covered services.

BluePlus 500 and BluePlus 1000 — For Lower Rates

Nearly all services covered under our BluePlus 500 and BluePlus 1000 coverage require a deductible before the Plan pays benefits, based on our Major Medical formula. BluePlus coverage is affordable while still protecting your financial security with \$1 million in coverage per member. The BluePlus 500 coverage has a \$500 yearly deductible per individual, limited to \$1,000 per family. BluePlus 1000 has a \$1,000 yearly deductible, limited to \$2,000 per family.

Major Medical Formula

After you have satisfied the annual deductible for your program, the Plan pays 80 percent of the next \$2,500 of covered expenses, and 100 percent of all covered expenses for the remainder of the calendar year. Coverage for mental and nervous conditions, and alcoholism is limited. Please see the Benefits Summary.

Our Promise

If you are not satisfied with your contract, you may return it to the Plan or any Plan agent within 10 days for a full refund. Please note, however, that this brochure explains the general features of the programs offered. It is not a contract. Complete terms and conditions of coverages are set forth in your contract.

Request Our Enrollment Package Today

If you have any questions regarding these programs or would like to enroll, call your agent or call us:

In the Seattle area: 367-1419

Washington Toll Free: 1-800-231-9519

Alaska Toll Free: 1-800-257-9557



Who's Eligible?

The programs described in this brochure are available only to applicants who are residents of the states of Washington and Alaska.

Family members eligible for coverage are you, your spouse, if under age 65, and your unmarried dependent children under age 23. Children, to be eligible, must be claimed as your income tax dependents. They may be natural children, stepchildren or legally-adopted children. Coverage may be continued for an enrolled, unmarried dependent over age 23 who is incapable of self-support because of developmental disability or physical handicap.

When Benefits Begin

If your application is approved, your coverage will become effective the first of the month following our receipt of your completed application. Your coverage begins immediately for accidents sustained on or after your effective date. However, certain conditions require a waiting period before benefits begin.

After your coverage becomes effective, there is a 30-day waiting period before coverage begins for any care or treatment involving an illness or ailment.

No benefits are provided for services rendered or supplies furnished for any pre-existing condition during the first twelve (12) consecutive months from the Member's effective date of coverage under the contract. If a Member is confined in a health care facility for a pre-existing condition when the 12-month waiting period ends, benefits will be provided only for services and supplies provided after the date of discharge.

A pre-existing condition is any illness, injury or condition, whether or not diagnosed, for which a Member has received treatment, consultation or diagnostic testing, or has taken prescribed or recommended medicines, during the twelve (12) months prior to the effective date of the Member's coverage.

Please note that infants, born on or after the Member's effective date, are not subject to the waiting periods specified above, provided they are properly added to the contract within sixty (60) days of birth.

In some cases certain pre-existing conditions may be excluded from your coverage. If this is the case, you will be notified in writing.

Maternity

You or your covered spouse are eligible for Major Medical maternity benefits, provided conception takes place after the coverage becomes effective and coverage is continuous until the date of delivery. Dependent daughters are not eligible for maternity benefits.

To Keep Rates Low

To help keep rates low, all three programs require you to seek a second surgical opinion before proceeding with certain named non-emergency, elective surgical procedures. (Charges for a second surgical opinion are not subject to a deductible, however.) We also require you to have your physician contact the Plan before you are admitted to a hospital for non-emergency treatment. Your benefits will be reduced if a required second surgical opinion is not obtained or if an inpatient hospital level of care is not medically necessary.

What Your Program Does Not Cover

- Benefits for illnesses OR injuries for which you are entitled to receive benefits under state or federal Workers' Compensation.
- Services supplied by a nonmember governmental hospital, except in a medical emergency.
- Services provided by a rest home, home for the aged, nursing home or convalescent home, except as specifically covered by your contract; all convalescent or custodial care.
- Hospitalization solely for diagnostic studies, physical examinations, checkups and medical evaluation. Routine physical and marital examinations. Treatment for obesity, including surgery and complications of surgery. Routine footcare procedures.
- Eye refractions, eyeglasses or the filling of eyeglasses to correct vision; hearing examinations or hearing aids; vision analysis, therapy or training related to muscular imbalance of the eye; orthoptics.
- Dental services and hospital care for the extraction of teeth or other dental services; services or supplies for treatment of temporomandibular joint (T.M.J.) dysfunction or myofascial pain-dysfunction (M.P.D.); upper or lower jaw augmentation or reduction procedures.
- Hospital admission or treatment primarily for rehabilitative care (including, but not limited to, speech and occupational therapy, except as specifically covered in your contract).

- Conditions caused by an act of war, armed invasion or aggression.
- Services or supplies not medically necessary, even if ordered by a court of law; any services or supplies for which no charge is made or would not have been made if the contract were not in effect; services or supplies for which you are not legally liable.
- Services or supplies for learning disabilities; marital, sexual or family counseling; vocational counseling; other counseling or training services; milieu therapy.
- Services or procedures which are not generally performed or accepted by the medical profession in Washington and Alaska, or which may be deemed experimental or investigative.
- Services for reproductive and sexual disorders, whether or not the consequences of illness, disease or injury, including but not limited to: impotency, frigidity, infertility, sterility, surgical sterilization, reversal of surgical sterilization, artificial insemination and in-vitro fertilization; services or drugs for sex transformations.
- Services, supplies, and procedures for cosmetic, plastic and reconstructive purposes, except as specifically provided for in your contract.
- Well baby care, including physical examinations, except hospital charges for infant nursery care while the mother is hospitalized and receiving maternity benefits.
- Private room charges during an inpatient stay.
- Any condition excluded in writing with this or any prior program.
- Services and supplies to the extent that benefits are payable under the terms of any insurance policy you or your spouse hold which provides payment towards medical expenses without a determination of liability for the injury. This includes automobile medical, auto no-fault or other similar type of policy.
- The primary surgeon's fee for certain named surgical procedures specified in the contract, unless a second surgical opinion is obtained.
- The primary surgeon's fee or the first \$200 of the admitting physician's fee in non-surgical cases when, in the reasonable opinion of the Plan, the inpatient level of care is not medically necessary.

Renewability, Cancellability and Termination

Your coverage under this program renews each month. It can be terminated without notice by the Plan if payment of the appropriate rate is not made when due. Your coverage under this program will also end if you or a family member fails to meet the program's eligibility rules.

If the cost of health care services or the use of benefits by those covered under this program increases, the Plan reserves the right to modify or withdraw this program, substitute another program or alter the rates charged for the program, following 30 days advance notice. If this is done, it will affect all Subscribers covered under this type of program.

BENEFITS SUMMARY*

Blue Ribbon

BluePlus 500
BluePlus 1000

HOSPITAL INPATIENT

Room & Board (semiprivate) Intensive Care Unit Ancillary Services	Paid in full, no deductible	Covered under Major Medical
Rehabilitative Care (semiprivate following acute care)	Paid in full up to 30 days per calendar year, no deductible	Covered under Major Medical up to \$5,000 per calendar year
Nervous & Mental	Paid in full up to 30 days per calendar year, then covered under Major Medical at a constant 50%	Covered under Major Medical at a constant 50% up to \$2,000 per calendar year
Drug Addiction	Paid in full up to 30 days per calendar year, then covered under Major Medical	Covered under Major Medical

HOSPITAL OUTPATIENT

Accidents, (All treatment within 7 days); Medical Emergencies (life-endangering); Minor Surgery, Chemotherapy X-Ray & Radium Therapy	Paid in full, no deductible	Covered under Major Medical
---	-----------------------------	-----------------------------

SKILLED NURSING FACILITY

Semiprivate room, Ancillary Services	Paid in full, no deductible	Covered under Major Medical up to \$5,000 per calendar year
--------------------------------------	-----------------------------	--

HOME HEALTH CARE

(Within 4 days of a 3-day or longer inpatient stay.)	Paid in full, no deductible	Covered under Major Medical
---	-----------------------------	-----------------------------

ALCOHOLISM TREATMENT

(Legally operated hospital or state- approved facility)	80% up to \$2,000 per calendar year, no deductible	Covered under Major Medical at a constant 80% up to \$2,000 per calendar year
--	---	---

OUTPATIENT REHABILITATIVE CARE

Up to \$20 per day/up to 45 days per calendar year, no deductible	Covered under Major Medical up to \$1,000 per calendar year
--	--

SURGICAL/MEDICAL

Surgeon's Fees, Assistant Surgeon, Anesthesia, Physicians' Calls, Prescription Drugs, Maternity; Ambulance, Medical Equipment and Prosthetic Devices	Covered under Major Medical	Covered under Major Medical
--	-----------------------------	-----------------------------

NERVOUS & MENTAL CONDITIONS

(Visits to a licensed physician or psychologist)	Covered under Major Medical at a constant 50% up to \$500 per calendar year	Covered under Major Medical at a constant 50% up to \$500 per calendar year
---	---	---

CHIROPRACTIC CARE

Covered under Major Medical up to \$500 per calendar year	Covered under Major Medical up to \$500 per calendar year
--	--

ACUTE NURSING

Covered under Major Medical up to \$2,500 per calendar year	Covered under Major Medical up to \$2,500 per calendar year
--	--

*This summary is not intended to be a contract. For complete details of the terms, conditions, coverages, exclusions, limitations, and other provisions of the plan, please refer to the actual plan documents. Coverage is subject to the terms, conditions, coverages, exclusions, limitations, and other provisions of the plan documents.

Washington Rates Payable Monthly Through Automatic Deduction

How to Pay for Your Blue Cross Plan Program

There are two options available for payment of your Blue Cross Subsidium Charges:

- \$450 Monthly Payment
- \$10 Monthly Payment

Subsidium charges are payable monthly through automatic deduction from your Washington State income tax withholding.

COVERAGE PROGRAM	YOUNGER OF YOU OR YOUR SPOUSE	SUBSCRIBER		SUBSCRIBER & SPOUSE		SUB. SPOUSE & CHILD(REN)		SUBSCRIBER & CHILD(REN)	
		REGULAR RATE	NON-SMOKER	REGULAR RATE	NON-SMOKER	REGULAR RATE	NON-SMOKER	REGULAR RATE	NON-SMOKER
BLUE RIBBON	Under 30	\$ 57.95	\$ 52.15	\$116.15	\$104.55	\$150.70	\$139.10	\$104.30	\$ 97.30
	30-34	65.50	58.95	130.35	117.30	164.00	150.95	108.65	101.15
	35-39	68.60	61.75	137.55	123.80	172.40	158.65	114.15	106.20
	40-44	75.10	67.60	150.25	135.25	182.45	167.45	118.35	109.75
	45-49	82.25	74.05	164.70	148.25	199.75	183.30	129.45	120.00
	50-54	88.20	79.40	176.50	158.85	211.50	193.85	135.05	125.05
	55-59	93.00	83.70	186.40	167.75	223.45	204.80	142.60	132.05
60-64	104.75	94.30	209.55	188.60	247.50	226.55	152.45	141.00	
BLUEPLUS 500	Under 30	\$ 45.60	\$ 41.05	\$ 91.15	\$ 82.05	\$118.40	\$109.30	\$ 82.05	\$ 76.55
	30-34	51.50	46.35	102.45	92.20	128.80	118.55	85.35	79.45
	35-39	53.85	48.45	107.75	97.00	135.40	124.65	89.70	83.50
	40-44	58.95	53.05	117.95	106.15	143.25	131.45	92.95	86.20
	45-49	64.55	58.10	129.40	116.45	156.90	143.95	101.65	94.25
	50-54	69.25	62.35	138.55	124.70	166.05	152.20	106.05	98.20
	55-59	72.95	65.65	146.35	131.70	175.40	160.75	111.95	103.65
60-64	82.25	74.05	164.60	148.15	194.35	177.90	119.70	110.70	
BLUEPLUS 1000	Under 30	\$ 37.15	\$ 33.45	\$ 74.50	\$ 67.05	\$ 96.65	\$ 89.20	\$ 66.95	\$ 62.45
	30-34	42.05	37.85	83.70	75.35	105.25	96.90	69.70	64.90
	35-39	44.00	39.60	88.00	79.20	110.60	101.80	73.25	68.20
	40-44	48.25	43.45	96.50	86.85	117.10	107.45	76.00	70.45
	45-49	52.85	47.55	105.80	95.20	128.20	117.60	83.00	76.95
	50-54	56.55	50.90	113.25	101.90	135.80	124.45	86.75	80.35
	55-59	59.60	53.65	119.55	107.60	143.45	131.50	91.45	84.70
60-64	67.25	60.50	134.55	121.10	158.90	145.45	97.80	90.45	

Alaska Rates Payable Monthly Through Automatic Deduction

How to Pay for Your Blue Cross Plan Program

There are two options available for payment of your Blue Cross Subsidium Charges:

- \$450 Monthly Payment
- \$10 Monthly Payment

Subsidium charges are payable monthly through automatic deduction from your Alaska State income tax withholding.

COVERAGE PROGRAM	YOUNGER OF YOU OR YOUR SPOUSE	SUBSCRIBER		SUBSCRIBER & SPOUSE		SUB. SPOUSE & CHILD(REN)		SUBSCRIBER & CHILD(REN)	
		REGULAR RATE	NON-SMOKER	REGULAR RATE	NON-SMOKER	REGULAR RATE	NON-SMOKER	REGULAR RATE	NON-SMOKER
BLUE RIBBON	Under 30	\$ 76.50	\$ 68.85	\$153.25	\$137.95	\$198.90	\$183.60	\$137.70	\$128.50
	30-34	86.45	77.80	172.15	154.95	216.45	199.25	143.30	133.40
	35-39	90.55	81.50	181.00	162.90	227.55	209.45	150.65	140.25
	40-44	99.15	89.25	198.30	178.45	240.85	221.00	156.20	144.85
	45-49	108.45	97.60	217.50	195.75	263.70	241.95	170.80	158.35
	50-54	116.40	104.75	233.00	209.70	279.15	255.85	178.35	165.15
	55-59	122.80	110.50	246.10	221.50	294.95	270.35	188.20	174.25
60-64	138.30	124.45	276.50	248.85	326.65	299.00	201.15	186.05	
BLUEPLUS 500	Under 30	\$ 60.10	\$ 54.10	\$120.35	\$108.30	\$156.10	\$144.05	\$108.20	\$100.95
	30-34	67.95	61.15	135.15	121.65	170.00	156.50	112.55	104.80
	35-39	71.20	64.10	142.05	127.85	178.70	164.50	118.35	110.20
	40-44	77.85	70.05	155.80	140.20	189.20	173.60	122.70	113.75
	45-49	85.20	76.70	170.75	153.70	207.05	190.00	134.10	124.30
	50-54	91.40	82.25	183.00	164.70	219.25	200.95	140.05	129.65
	55-59	96.40	86.75	193.25	173.95	231.65	212.35	147.80	136.85
60-64	108.65	97.80	217.15	195.45	256.60	234.90	157.95	146.10	
BLUEPLUS 1000	Under 30	\$ 49.15	\$ 44.25	\$ 98.35	\$ 88.50	\$127.65	\$117.80	\$ 88.35	\$ 82.45
	30-34	55.45	49.90	110.45	99.40	138.90	127.85	91.95	85.60
	35-39	58.15	52.35	116.15	104.55	146.05	134.45	96.65	89.95
	40-44	63.60	57.25	127.30	114.55	154.55	141.80	100.25	92.95
	45-49	69.60	62.65	139.55	125.60	168.95	155.00	109.65	101.60
	50-54	74.75	67.30	149.50	134.55	179.15	164.20	114.45	105.95
	55-59	78.80	70.90	157.85	142.05	189.25	173.45	120.70	111.75
60-64	88.80	79.90	177.45	159.70	209.60	191.85	129.05	119.35	



Blue Cross
of Washington and Alaska

We'll take care of it.

INSURANCE OVERVIEW
HOUSE JUDICIARY AND LABOR & COMMERCE COMMITTEES
FEBRUARY 3 and 5 - 1:30-3:00 p.m.
FEBRUARY 4 - 12:30-2:00 p.m.
House Judiciary Committee Room - Capitol 120



A. TUESDAY, FEB. 3, 1:30-3:00 p.m. - State Agency Perspective, Municipalities, School Boards

1. State Agency Perspective (30 Minutes)

a) John George, Director, Div. of Insurance

1) Update on Insurance Availability & Affordability

a> Health Care

1> Consumer Health Insurance

2> Malpractice Insurance MICA, MIEC

b> Liability Insurance

1> Marine - *big real problem - Congress reviewing*

2> Aviation

2) Update on Insurance Pooling, Self Insurance and Reciprocals

2. Municipalities (15 Minutes)

a) Scott Burgess, Executive Director, Alaska Municipal League, *Jody Smith - AML insurance person, Anchorage*

1) Update on Insurance Availability and Affordability *currently insuring over 100 munis & school districts for liability*

2) Use of Pooling and Self Insurance

3. School Boards (15 Minutes)

a) Sharon Young, Association of Alaska School Boards

1) Update on Insurance Availability and Affordability

2) Use of "Vermont Captive"

B. WEDNESDAY, FEB. 4, 12:30-2:00 p.m. - Health Insurance

1. Consumer Health Insurance - Insurer Perspective

a) Martin Tirador, Blue Cross (10 Minutes)

1) Availability and Affordability

*PSG same as
worker's comp for
crew members*



With Our Plan,
You've Got Confidence



Blue Cross
of Washington and Alaska

THREE PROGRAMS, THREE RATES: ONE IS RIGHT FOR YOU

Three programs offering a choice of deductibles and three different rates. One of them is sure to meet your needs. And you can be confident of their quality because all three are from an organization you can trust.

With each of the programs you get \$1 million in coverage per member, and these advantages:

Worldwide Coverage — Your coverage is good around the world. And there's no need to reapply if you relocate anywhere within Washington and Alaska.

Choice of Physicians — You choose the physicians and specialists you want. You're not limited to one clinic or a list of doctors. No separate referral is required to consult with specialists.

Maternity Benefits — Maternity benefits are provided for you or your covered spouse without a separate deductible.

More Covered Services — Coverage is provided for chiropractic care, mental and nervous conditions, alcoholism, drug addiction, and prescription drugs in addition to medical and surgical benefits.

Nonsmoker Discount — If you and your covered spouse have been nonsmokers for at least one year, you qualify for a substantial discount of up to 10 percent.

Blue Ribbon — Our Finest Coverage

Our Blue Ribbon program has no deductible for hospital inpatient or selected outpatient services. The paid-in-full coverage extends to skilled nursing facilities, home health care and minor surgery on an outpatient basis. Please see the Benefits Summary for full details.

A \$200 yearly deductible per individual, limited to \$600 per family, applies to other covered services.

BluePlus 500 and BluePlus 1000 — For Lower Rates
Nearly all services covered under our BluePlus 500 and BluePlus 1000 coverage require a deductible before the Plan pays benefits, based on our Major Medical formula. BluePlus coverage is affordable while still protecting your financial security with \$1 million in coverage per member. The BluePlus 500 coverage has a \$500 yearly deductible per individual, limited to \$1,000 per family. BluePlus 1000 has a \$1,000 yearly deductible, limited to \$2,000 per family.

Major Medical Formula

After you have satisfied the annual deductible for your program, the Plan pays 80 percent of the next \$2,500 of covered expenses, and 100 percent of all covered expenses for the remainder of the calendar year. Coverage for mental and nervous conditions, and alcoholism is limited. Please see the Benefits Summary.

Our Promise

If you are not satisfied with your contract, you may return it to the Plan or any Plan agent within 10 days for a full refund. Please note, however, that this brochure explains the general features of the programs offered. It is not a contract. Complete terms and conditions of coverages are set forth in your contract.

Request Our Enrollment Package Today

If you have any questions regarding these programs or would like to enroll, call your agent or call us:

In the Seattle area: 367-1419
Washington Toll Free: 1-800-231-9519
Alaska Toll Free: 1-800-257-9557



Who's Eligible?

The programs described in this brochure are available only to applicants who are residents of the states of Washington and Alaska.

Family members eligible for coverage are you, your spouse, if under age 65, and your unmarried dependent children under age 23. Children, to be eligible, must be claimed as your income tax dependents. They may be natural children, stepchildren or legally-adopted children. Coverage may be continued for an enrolled, unmarried dependent over age 23 who is incapable of self-support because of developmental disability or physical handicap.

When Benefits Begin

If your application is approved, your coverage will become effective the first of the month following our receipt of your completed application. Your coverage begins immediately for accidents sustained on or after your effective date. However, certain conditions require a waiting period before benefits begin.

After your coverage becomes effective, there is a 30-day waiting period before coverage begins for any care or treatment involving an illness or ailment.

No benefits are provided for services rendered or supplies furnished for any pre-existing condition during the first twelve (12) consecutive months from the Member's effective date of coverage under the contract. If a Member is confined in a health care facility for a pre-existing condition when the 12-month waiting period ends, benefits will be provided only for services and supplies provided after the date of discharge.

A pre-existing condition is any illness, injury or condition, whether or not diagnosed, for which a Member has received treatment, consultation or diagnostic testing, or has taken prescribed or recommended medicines, during the twelve (12) months prior to the effective date of the Member's coverage.

Please note that infants, born on or after the Member's effective date, are not subject to the waiting periods specified above, provided they are properly added to the contract within sixty (60) days of birth.

In some cases certain pre-existing conditions may be excluded from your coverage. If this is the case, you will be notified in writing.

Maternity

You or your covered spouse are eligible for Major Medical maternity benefits, provided conception takes place after the coverage becomes effective and coverage is continuous until the date of delivery. Dependent daughters are not eligible for maternity benefits.

To Keep Rates Low

To help keep rates low, all three programs require you to seek a second surgical opinion before proceeding with certain named non-emergency, elective surgical procedures. (Charges for a second surgical opinion are not subject to a deductible, however.) We also require you to have your physician contact the Plan before you are admitted to a hospital for non-emergency treatment. Your benefits will be reduced if a required second surgical opinion is not obtained or if an inpatient hospital level of care is not medically necessary.

What Your Program Does Not Cover

- Benefits for illnesses OR injuries for which you are entitled to receive benefits under state or federal Workers' Compensation.
- Services supplied by a nonmember governmental hospital, except in a medical emergency.
- Services provided by a rest home, home for the aged, nursing home or convalescent home, except as specifically covered by your contract; all convalescent or custodial care.
- Hospitalization solely for diagnostic studies, physical examinations, checkups and medical evaluation. Routine physical and marital examinations. Treatment for obesity, including surgery and complications of surgery. Routine footcare procedures.
- Eye refractions, eyeglasses or the filling of eyeglasses to correct vision; hearing examinations or hearing aids; vision analysis, therapy or training related to muscular imbalance of the eye; orthoptics.
- Dental services and hospital care for the extraction of teeth or other dental services; services or supplies for treatment of temporomandibular joint (T.M.J.) dysfunction or myofascial pain-dysfunction (M.P.D.); upper or lower jaw augmentation or reduction procedures.
- Hospital admission or treatment primarily for rehabilitative care (including, but not limited to, speech and occupational therapy, except as specifically covered in your contract).

- Conditions caused by an act of war, armed invasion or aggression.
- Services or supplies not medically necessary, even if ordered by a court of law; any services or supplies for which no charge is made or would not have been made if the contract were not in effect; services or supplies for which you are not legally liable.
- Services or supplies for learning disabilities; marital, sexual or family counseling; vocational counseling; other counseling or training services; milieu therapy.
- Services or procedures which are not generally performed or accepted by the medical profession in Washington and Alaska, or which may be deemed experimental or investigative.
- Services for reproductive and sexual disorders, whether or not the consequences of illness, disease or injury, including but not limited to: impotency, frigidity, infertility, sterility, surgical sterilization, reversal of surgical sterilization, artificial insemination and in-vitro fertilization; services or drugs for sex transformations.
- Services, supplies, and procedures for cosmetic, plastic and reconstructive purposes, except as specifically provided for in your contract.
- Well baby care, including physical examinations, except hospital charges for infant nursery care while the mother is hospitalized and receiving maternity benefits.
- Private room charges during an inpatient stay.
- Any condition excluded in writing with this or any prior program.
- Services and supplies to the extent that benefits are payable under the terms of any insurance policy you or your spouse hold which provides payment towards medical expenses without a determination of liability for the injury. This includes automobile medical, auto no-fault or other similar type of policy.
- The primary surgeon's fee for certain named surgical procedures specified in the contract, unless a second surgical opinion is obtained.
- The primary surgeon's fee or the first \$200 of the admitting physician's fee in non-surgical cases when, in the reasonable opinion of the Plan, the inpatient level of care is not medically necessary.

Renewability, Cancellability and Termination

Your coverage under this program renews each month. It can be terminated without notice by the Plan if payment of the appropriate rate is not made when due. Your coverage under this program will also end if you or a family member fails to meet the program's eligibility rules.

If the cost of health care services or the use of benefits by those covered under this program increases, the Plan reserves the right to modify or withdraw this program, substitute another program or alter the rates charged for the program, following 30 days advance notice. If this is done, it will affect all Subscribers covered under this type of program.

BENEFITS SUMMARY*

	Blue Ribbon	BluePlus 500 BluePlus 1000
HOSPITAL INPATIENT		
Room & Board (semiprivate) Intensive Care Unit Ancillary Services	Paid in full, no deductible	Covered under Major Medical
Rehabilitative Care (semiprivate following acute care)	Paid in full up to 30 days per calendar year, no deductible	Covered under Major Medical up to \$5,000 per calendar year
Nervous & Mental	Paid in full up to 30 days per calendar year, then covered under Major Medical at a constant 50%	Covered under Major Medical at a constant 50% up to \$2,000 per calendar year
Drug Addiction	Paid in full up to 30 days per calendar year, then covered under Major Medical	Covered under Major Medical
HOSPITAL OUTPATIENT		
Accidents, (All treatment within 7 days); Medical Emergencies (life-endangering); Minor Surgery; Chemotherapy X-Ray & Radium Therapy	Paid in full, no deductible	Covered under Major Medical
SKILLED NURSING FACILITY		
Semiprivate room; Ancillary Services	Paid in full, no deductible	Covered under Major Medical up to \$5,000 per calendar year
HOME HEALTH CARE (Within 4 days of a 3-day or longer inpatient stay.)		
	Paid in full, no deductible	Covered under Major Medical
ALCOHOLISM TREATMENT (Legally operated hospital or state- approved facility)		
	80% up to \$2,000 per calendar year, no deductible	Covered under Major Medical at a constant 80% up to \$2,000 per calendar year
OUTPATIENT REHABILITATIVE CARE		
	Up to \$20 per day/up to 45 days per calendar year, no deductible	Covered under Major Medical up to \$1,000 per calendar year
SURGICAL/MEDICAL		
Surgeon's Fees, Assistant Surgeon, Anesthesia, Physicians' Calls, Prescription Drugs; Maternity; Ambulance, Medical Equipment and Prosthetic Devices	Covered under Major Medical	Covered under Major Medical
NERVOUS & MENTAL CONDITIONS (Visits to a licensed physician or psychologist)		
	Covered under Major Medical at a constant 50% up to \$500 per calendar year	Covered under Major Medical at a constant 50% up to \$500 per calendar year
CHIROPRACTIC CARE		
	Covered under Major Medical up to \$500 per calendar year	Covered under Major Medical up to \$500 per calendar year
ACUTE NURSING		
	Covered under Major Medical up to \$2,500 per calendar year	Covered under Major Medical up to \$2,500 per calendar year

*Benefits are not provided for the portion of any fee that exceeds the
plan's guideline. By definition, the vast majority of fees charged by
health care providers fall within these guidelines.

Washington Rates Payable Monthly Through Automatic Deduction

If accepted, in order to begin coverage you must include two months premium with submission of the health statement application.

How to Pay for Your Blue Cross Plan Program

There are two options available for payment of your Blue Cross Subscription Charges:

- ABC Monthly Payment
- Bi-monthly Billing by Mail

COVERAGE PROGRAM	YOUNGER OF YOU OR YOUR SPOUSE	SUBSCRIBER		SUBSCRIBER & SPOUSE		SUB. SPOUSE & CHILD(REN)		SUBSCRIBER & CHILD(REN)	
		REGULAR RATE	NON-SMOKER	REGULAR RATE	NON-SMOKER	REGULAR RATE	NON-SMOKER	REGULAR RATE	NON-SMOKER
BLUE RIBBON	Under 30	\$ 57.95	\$ 52.15	\$116.15	\$104.55	\$150.70	\$139.10	\$104.30	\$ 97.30
	30-34	65.50	58.95	130.35	117.30	164.00	150.95	108.65	101.15
	35-39	68.60	61.75	137.55	123.80	172.40	158.65	114.15	106.20
	40-44	75.10	67.60	150.25	135.25	182.45	167.45	118.35	109.75
	45-49	82.25	74.05	164.70	148.25	199.75	183.30	129.45	120.00
	50-54	88.20	79.40	176.50	158.85	211.50	193.85	135.05	125.05
	55-59	93.00	83.70	186.40	167.75	223.45	204.80	142.60	132.05
60-64	104.75	94.30	209.55	188.60	247.50	226.55	152.45	141.00	
BLUEPLUS 500	Under 30	\$ 45.60	\$ 41.05	\$ 91.15	\$ 82.05	\$118.40	\$109.30	\$ 82.05	\$ 76.55
	30-34	51.50	46.35	102.45	92.20	128.80	118.55	85.35	79.45
	35-39	53.85	48.45	107.75	97.00	135.40	124.65	89.70	83.50
	40-44	58.95	53.05	117.95	106.15	143.25	131.45	92.95	86.20
	45-49	64.55	58.10	129.40	116.45	156.90	143.95	101.65	94.25
	50-54	69.25	62.35	138.55	124.70	166.05	152.20	106.05	98.20
	55-59	72.95	65.65	146.35	131.70	175.40	160.75	111.95	103.65
60-64	82.25	74.05	164.60	148.15	194.35	177.90	119.70	110.70	
BLUEPLUS 1000	Under 30	\$ 37.15	\$ 33.45	\$ 74.50	\$ 67.05	\$ 96.65	\$ 89.20	\$ 66.05	\$ 62.45
	30-34	42.05	37.85	83.70	75.35	105.25	96.90	69.70	64.90
	35-39	44.00	39.60	88.00	79.20	110.60	101.80	73.25	68.20
	40-44	48.25	43.45	96.50	86.85	117.10	107.45	76.00	70.45
	45-49	52.85	47.55	105.80	95.20	128.20	117.60	83.00	76.95
	50-54	56.55	50.90	113.25	101.90	135.80	124.45	86.75	80.35
	55-59	59.60	53.65	119.55	107.60	143.45	131.50	91.45	84.70
60-64	67.25	60.50	134.55	121.10	158.90	145.45	97.80	90.45	

Alaska Rates Payable Monthly Through Automatic Deduction

If accepted, in order to begin coverage you must include two months premium with submission of the health statement application.

How to Pay for Your Blue Cross Plan Program

There are two options available for payment of your Blue Cross Subscription Charges:

- ABC Monthly Payment
- Bi-monthly Billing by Mail

COVERAGE PROGRAM	YOUNGER OF YOU OR YOUR SPOUSE	SUBSCRIBER		SUBSCRIBER & SPOUSE		SUB. SPOUSE & CHILD(REN)		SUBSCRIBER & CHILD(REN)	
		REGULAR RATE	NON-SMOKER	REGULAR RATE	NON-SMOKER	REGULAR RATE	NON-SMOKER	REGULAR RATE	NON-SMOKER
BLUE RIBBON	Under 30	\$ 76.50	\$ 68.85	\$153.25	\$137.95	\$198.90	\$183.60	\$137.70	\$128.50
	30-34	86.45	77.80	172.15	154.95	216.45	199.25	143.30	133.40
	35-39	90.55	81.50	181.00	162.90	227.55	209.45	150.65	140.25
	40-44	99.15	89.25	198.30	178.45	240.85	221.00	156.20	144.85
	45-49	108.45	97.60	217.50	195.75	263.70	241.95	170.80	158.35
	50-54	116.40	104.75	233.00	209.70	279.15	255.85	178.35	165.15
	55-59	122.80	110.50	246.10	221.50	294.95	270.35	188.20	174.25
60-64	138.30	124.45	276.50	248.85	326.65	299.00	201.15	186.05	
BLUEPLUS 500	Under 30	\$ 60.10	\$ 54.10	\$120.35	\$108.30	\$156.10	\$144.05	\$108.20	\$100.95
	30-34	67.95	61.15	135.15	121.65	170.00	156.50	112.55	104.80
	35-39	71.20	64.10	142.05	127.85	178.70	164.50	118.35	110.20
	40-44	77.85	70.05	155.80	140.20	189.20	173.60	122.70	113.75
	45-49	85.20	76.70	170.75	153.70	207.05	190.00	134.10	124.30
	50-54	91.40	82.25	183.00	164.70	219.25	200.95	140.05	129.65
	55-59	96.40	86.75	193.25	173.95	231.65	212.35	147.80	136.85
60-64	108.65	97.80	217.15	195.45	256.60	234.90	157.95	146.10	
BLUEPLUS 1000	Under 30	\$ 49.15	\$ 44.25	\$ 98.35	\$ 88.50	\$127.65	\$117.80	\$ 88.35	\$ 82.45
	30-34	55.45	49.90	110.45	99.40	138.90	127.85	91.95	85.60
	35-39	58.15	52.35	116.15	104.55	146.05	134.45	96.65	89.95
	40-44	63.60	57.25	127.30	114.55	154.55	141.80	100.25	92.95
	45-49	69.60	62.65	139.55	125.60	168.95	155.00	109.65	101.60
	50-54	74.75	67.30	149.50	134.55	179.15	164.20	114.45	105.95
	55-59	78.80	70.90	157.85	142.05	189.25	173.45	120.70	111.75
60-64	88.80	79.90	177.45	159.70	209.60	191.85	129.05	119.35	



Blue Cross
of Washington and Alaska

We'll take care of it.

INSURANCE OVERVIEW
HOUSE JUDICIARY AND LABOR & COMMERCE COMMITTEES
FEBRUARY 3 and 5 - 1:30-3:00 p.m.
FEBRUARY 4 - 12:30-2:00 p.m.
House Judiciary Committee Room - Capitol 120

A. TUESDAY, FEB. 3, 1:30-3:00 p.m. - State Agency Perspective,
Municipalities, School
Boards

1. State Agency Perspective (30 Minutes)

a) John George, Director, Div. of Insurance

1) Update on Insurance Availability & Affordability

a> Health Care

1> Consumer Health Insurance

2> Malpractice Insurance MICA, MIEC

b> Liability Insurance

1> Marine - P&G - real problem - Congress reviewing

2> Aviation

2) Update on Insurance Pooling, Self Insurance and
Reciprocals

2. Municipalities (15 Minutes)

a) Scott Burgess, Executive Director, Alaska Municipal
League, *Jody Smith - AML insurance person, Anchorage*

1) Update on Insurance Availability and
Affordability *currently insuring over 100 munis of school districts for liability*

2) Use of Pooling and Self Insurance

3. School Boards (15 Minutes)

a) Sharon Young, Association of Alaska School Boards

1) Update on Insurance Availability and
Affordability

2) Use of "Vermont Captive"

B. WEDNESDAY, FEB. 4, 12:30-2:00 p.m. - Health Insurance

1. Consumer Health Insurance - Insurer Perspective

a) Martin Tirador, Blue Cross (10 Minutes)

1) Availability and Affordability

*P&G same as
worker's comp for
crew members*

2. Malpractice Insurance

a) Insurer Perspective

- 1) Bill Brock, Medical Indemnity Corp. of AK (MICA)
(10 Minutes)

b) Insured Perspective

1) Hospitals

- a> Mike Lockwood, Health Association of Alaska
(10 Minutes)

- b> John Vowell, Wrangell General Hospital (10
Minutes)

- c> ~~Keith Campbell, Seward General Hospital (10
Minutes)~~ TBA

2) Physicians

- a> Dr. Tom Wood, Petersburg (10 Minutes)

C. THURSDAY, FEB. 5, 1:30-3:00 p.m. - Workers Compensation,
Marine and Aviation

1. Workers' Compensation

a) Benefits

- 1) Jackie McClintock, Director, State Division
Workers' Comp (15 Minutes)

b) Rate Structure

- 1) John George, Director, Division of Insurance (15
Minutes)

2. Marine Insurance - Availability and Affordability

a) Insurer Perspective

- 1) Northern Marine Insurance - Mike Miller or Lach
Zemp (10 Minutes)

b) Insured Perspective

- 1) Bill Hall, Alaska Commercial Fishing and
Agriculture Bank (10 Minutes)

3. Aviation Insurance - Availability and Affordability

- a) Reed Stoops - Air Carriers Association (10 Minutes)

ADDENDUM TO INSURANCE OVERVIEW AGENDA

Day 3; February 5:

Workers' Compensation

c) Rate Impact on Employers and Employees

- 1) Frank Mears - Workers' Compensation committee of Alaska (10 minutes)

*
* DELIVER TO: LIOCFWW *
*
* ORIGINAL *
* SENT: 02/04/87 TIME: 18:36 *
* FROM: LIOCSOL *
* SUBJECT: FINAL STATS/INSURANCE OVERVIEW *
* PRINT DATE: 02/04/87 TIME: 18:36 *
*



* * * FINAL STATS * * *

SOLD JT NA

TO OBSERVE:

1. KURT KRISTENSEN RT. 1 BOX 945 KENAI 776-8591

To: house
judiciary
insurance
7C
2/14/87

 *
 * DELIVER TO: LIOCFWW
 *
 * ORIGINAL
 * SENT: 02/04/87 TIME: 18:19
 * FROM: LIOCSIT
 * SUBJECT: FINAL STATS INSURANCE OVERVIEW
 * PRINT DATE: 02/04/87 TIME: 18:19
 *



2/4/87
 HOUSE JUDICIARY AND LABOR AND COMMERCE
 INSURANCE OVERVIEW
 SITKA
 THERESA WYMAN

FINAL STATS
 PARTICIPANT LIST

NAME/REPRESENTING	ADDRESS	PHONE #	T	0
1. REED REYNOLDS, SE EMS COUNCIL, 219 SEWARD, SITKA				0
2. MARY THOMPSON, 326 MERRILL ST., SITKA				0
3. FRANK L. SUTTON, MT. EDGEcombe HOSPITAL, 222 TONGASS				0
4. CHARLES BOVEE, SEARHC, 222 TONGASS, SITKA				0
5. ED MALEWSKI, BOX 133				0
0 TESTIFIED				
0 UNABLE				
5 OBSERVING				
5 TOTAL				
12:30PM-1:05 PM	START/END TIME			

* DELIVER TO: LIOCFWW

* ORIGINAL

* SENT: 02/04/87 TIME: 18:27
* FROM: LIOCKTN
* SUBJECT: FINAL STATS 2/4/INS.
* PRINT DATE: 02/04/87 TIME: 18:28

TO: LTCCJNU, LIOCFWW
FROM: MODERATOR KETCHIKAN
PARTICIPANT LIST FOR
HOUSE JUDICIARY AND LABOR AND COMMERCE COMMITTEES
FEBRUARY 4, 1987 - "LISTEN ONLY"
TO OBSERVE:

- 1. JODI PERLHUTTER/SEANSA, 215 MAIN - SUITE 215, KTN 225-9681
- 2. SISTER BARBARA HAASE/KGH, 3100 TONGASS, KTN 225-3171

TESTIFIED: 0
UNABLE TO TESTIFY: 0
OBSERVED: 2
TOTAL: 2

START TIME: 12:40P
END TIME: 2:10P
MODERATOR: EVELYN



* DELIVER TO: LIOCFWW

* ORIGINAL

* SENT: 02/04/87 TIME: 18:35

* FROM: LIOCKTN

* SUBJECT: FINAL STATS/WRG 2/4-INS

* PRINT DATE: 02/04/87 TIME: 18:36

TO: LTCCJNU, LIOCFWW
FROM: MODERATOR (WRANGELL), NABEL FENNIMORE
PARTICIPANT LIST FOR:
HOUSE JUDICIARY AND LABOR AND COMMERCE COMMITTEES
FEBRUARY 4, 1987 - "LISTEN ONLY"

TO OBSERVE:

1. KAREN HOFSTAD, BOX 20, WRG 874-2359
2. BRYAN JOHNSON/KSTK RADIO, BOX 1141, WRG 874-2345
3. JIM GOVE/EC. DIR., BOX 531, WRG 874-2381
4. LURINE MCGEE, BOX 80, WRG 874-3356
5. JOYCE BRYNER, BOX 408, WRG 874-3174

TESTIFIED: 0
UNABLE TO TESTIFY: 0
OBSERVED: 5
TOTAL: 5

START TIME: 12:40 P
END TIME: 2:10 P
MODERATOR: EVELYN

* DELIVER TO: <LTCCJNU

* ORIGINAL

* SENT: 02/04/87 TIME: 14:22

* FROM: LIOCANC

* SUBJECT: H JUD--INSURANCE OVERVIEW

* PRINT DATE: 02/04/87 TIME: 14:22

*** FINAL TELECONFERENCE STATISTICS ***

DATE: _____ FEBRUARY 4, 1987 _____
 SITE: _____ ANCHORAGE _____
 SPONSOR: _____ HOUSE JUDICIARY _____
 SUBJECT: _____ INSURANCE OVERVIEWS _____
 LOCAL MODERATOR: _____ DAVID J _____

TESTIFIED:

NAME\REPRESENTING	ADDRESS	PHONE #
MIKE LOCKWOOD	240 HOSPITAL PLACE 99508	262-4404
BILL PARGETER	915 E 82ND AVE	349-4663

OBSERVED:

NAME\REPRESENTING	ADDRESS	PHONE #
LYNN CHASE	3319 WELLS CIRCLE	261-3117
AL CHRUSO	3200 PROVIDENCE DR 99508	562-2211
TERRIE GOTTSTEIN	604 W 2ND AVE 99501	276-1130
BOB NESTEL	PO BOX 16810 99577	694-4372
GERALDINE BROWN	STR 1; BOX 2711 99577	688-2116
BONNIE NELSON	STR 1; BOX 2708 99577	688-3017

TESTIFIED: _____ 02 _____ START TIME: 12:30PM__
 OBSERVED: _____ 06 _____ END TIME: __2:10PM__

 * DELIVER TO. LIOCFWW *
 * ORIGINAL *
 * SENT: 02/04/87 TIME: 18:39 *
 * FROM: LIOCFSG *
 * SUBJECT: INSURANCE Q/VIEW T/C *
 * PRINT DATE: 02/04/87 TIME: 18:41 *



*** FINAL T/C STATS ***

DATE: FEB. 4, 1987
 SITE: PETERSBURG
 SPONSOR: H. JUD
 SUBJECT: INSURANCE OVERVIEW
 LOCAL MODERATOR: DOROTHY PENTTILA

TESTIFIED:

	NAME/REPRESENTING	ADDRESS	PHONE
1.	TON WOOD M.D.	BOX 630	772-3635

OBSERVED:

	NAME/REPRESENTING	ADDRESS	PHONE
1.	GARY GRANDY/HOSPITAL	BOX 589	772-4291
2.	BOD TRAEZ/PSS. PILOT	BOX 630	772-3535
3.	BARBARA SHORT/HOSP. BOARD	BOX 1136	772-3465
4.	NORMA J. TENFJORD/H/BOARD	BOX 476	772-4552
5.	GERALD J. LIND/SELF	BOX 648	772-4517
6.	SUE ERLIKSON/PSG. INSURANCE	BOX 529	772-3858

TESTIFIED: 1 TIME START: 12:30 PM
 OBSERVED: 6 TIME END: 2:00 PM
 TOTAL: 7

MEDICAL INDEMNITY CORPORATION OF ALASKA (MICA)

A brief history and description.
Prepared by Rep. John Sund's office;
January 30, 1987

CREATION

MICA is an insurance company created by the Alaska Legislature to provide professional liability insurance to Alaskan physicians and surgeons, hospitals and related health care organizations. The company was established in response to the lack of available malpractice insurance in the state in the mid-1970s. MICA commenced business on June 28, 1976.

STRUCTURE

MICA is administered by a nine-member board appointed by the governor and confirmed by the Legislature. The board consists of four physicians, a hospital administrator, two insurance industry professionals and two persons unrelated to the health care and insurance industries. The board maintains a plan of operation, which is subject to approval by the state director of the Division of Insurance.

The Legislature deliberately set up MICA to be a free-standing corporation with no direct political involvement in its operations. MICA reports to the Division of Insurance in the same manner as all insurance companies operating in the state. However, unlike other insurance companies, the Division of Insurance does have an extended relationship with MICA through approval of the plan of operation and capitalization loans (explained below). The Division is also invited to all MICA board meetings, but does not vote.

MICA is based in Anchorage. The daily operations are managed by an independent consulting firm, Marsh & McLennan. But the MICA board is moving toward self-management. MICA's actuary is Milliman & Robertson.

The state ruled that MICA is exempt from income taxes. That has not, to date, been challenged by the IRS.

By statute, MICA may be terminated if it posts written premiums for two consecutive years of less than 35 percent of all premiums written in the state for physicians' medical malpractice insurance, or posts premiums for one calendar year of less than 20 percent of all malpractice premiums in the state. The decision to terminate would be made by the director of insurance following public hearings.

CAPITALIZATION

The Legislature established in the Department of Commerce and Economic Development a medical malpractice liability revolving loan fund to capitalize MICA. The fund is administered by the director of insurance. The original loan was \$3 million, payable at 7 percent interest. MICA is paying interest, but there is no due date on the principal and the state loan is subordinate to all other obligations of the corporation. MICA must make a loan repayment in the event of an underwriting profit, but that has not happened to date. The board intends to pay off the loan in 15 years.

In 1979, the Division of Treasury purchased the \$3 million note from Commerce and Economic Development, thereby putting \$3 million more into the fund for MICA to borrow in the future. In late 1986, MICA requested an additional \$3 million loan to offset losses experienced in 1985 (see explanation below). The director of insurance approved a \$2 million loan which, by statute, is payable in five years at 6 percent interest. The fund balance is now \$1 million.

FINANCIAL STATUS

Due largely to a reinsurance problem (explained below), MICA posted a \$2.14 million loss in 1985. The company used its entire \$2 million surplus built up in prior years to offset the loss. (Hence the reason for the loan request in 1986.) MICA's assets totaled \$10.47 million at the end of 1985 with \$6.5 million in reserve for claim payments. (See attached annual report for further financial data.)

REINSURANCE PROBLEM OF 1985

In late 1984, after MICA had set its policy rates for 1985, the company faced a problem with its reinsurers which led to a financial loss. One of the company's reinsurers denied renewal of MICA's policy while another approximately tripled its premium rate. Not only did the reinsurance cost increase, the coverage diminished, leaving MICA with greater personal risk in claim settlements. Because of the late notice on the reinsurance rates, MICA could not reflect the increase in its premium rates. Thus, 1985 posted a large loss. MICA also had a couple of large claims in 1985 which the reinsurance did not fully cover, adding to MICA's dip into its surplus. MICA obtained better reinsurance in 1986 and for 1987, but the company also has to recoup some of the 1985 losses. As a result, and as a reflection of malpractice insurance in general, MICA's policy rates increased as much as 90 percent from 1985 to 1986.

PRESENT SITUATION WITH HOSPITALS

MICA recently established a new policy requiring that all physicians in MICA-covered hospitals carry \$500,000 liability insurance. Meeting that requirement is causing financial difficulties for at least 7 of the 12 hospitals insured by MICA in 1986:

Wrangell
Cordova
Homer
Petersburg
Seward
Sitka
Palmer

The hospitals were given a Feb. 28, 1987, deadline to meet the requirement or risk denial of coverage by MICA. The hospitals are faced with the dilemma of requiring each of their physicians to carry \$500,000 liability, which many cannot afford; purchasing the physicians' insurance for them; self-insuring; or going bare.

Addendum: According to MICA, most claims against hospitals involve doctors and 85.4 percent of MICA's pending claims include hospitals.

ASSOCIATION OF ALASKA SCHOOL BOARDS

316 W. 11th St. • Juneau, Alaska 99801-1510 • (907) 586-1083

TESTIMONY

OF

THE ASSOCIATION OF ALASKA SCHOOL BOARDS

Sharon Young
Director Of Membership Services
February 3, 1987

AVAILABILITY AND AFFORDABILITY
OF PROPERTY AND LIABILITY INSURANCE
FOR
SCHOOL DISTRICTS

Property Insurance

Problems experienced by school districts in the last couple of years in the area of property insurance, caused by the cyclical nature of the insurance industry, have eased considerably. The availability and affordability of property insurance will probably continue to improve and stabilize. One major reason is the formation in 1986 of the Alaska Schools Insurance Company (ASIC) - a pooling arrangement made up of 29 school districts to provide property insurance. ASIC was able to provide property coverage to districts that reported difficulty in securing coverage at a rate they felt they could afford. A primary goal of ASIC is to stabilize rates so that districts will not be subject to the cyclical swings traditional in the commercial insurance market.

School districts which did not join ASIC were typically very small city/borough school districts and large urban districts. The small city/borough districts have not experienced as many problems in finding coverage and generally enjoy lower rates because of adequate fire protection, consistently good loss records, and good building construction with sprinkler systems. The large urban districts secure their property insurance through joint insurance arrangements with their municipal governments and by retaining a high self-insured retention have not been affected as severely by the extreme premium increases in recent years.

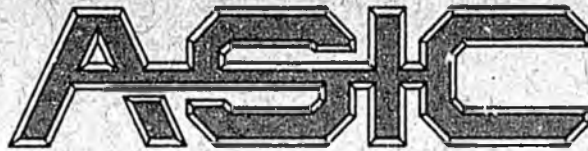
Liability Insurance

Brokers in Anchorage, Fairbanks, and Juneau report that there are a very limited number of carriers writing liability coverage for Alaskan school districts and they are doing that very selectively. One carrier will only write renewal business, not taking on any new school accounts. Two others are mainly interested in providing coverage for larger districts such as Anchorage, Fairbanks, Kenai and Juneau, and aren't generally willing to cover the smaller city or rural districts. The Alaska Municipal League (AML) Liability Program has been opened to school districts, but their coverage is limited to \$500,000.

Many districts last year reported only being able to secure \$500,000 limits, with no umbrella coverage available. It appears that this year the majority have been able to secure coverage with a \$1,000,000 limit. Some umbrella coverage is available, but the cost is generally considered to be prohibitive.

Most policies this year also contain exclusions for most athletic activities, causing many districts to severely curtail their extracurricular programs.

Regarding affordability, brokers report that most liability insurance is being written at the standard manual rate. Given school districts' current budget problems, the answer as to whether that insurance is "affordable" is bound to be subjective.

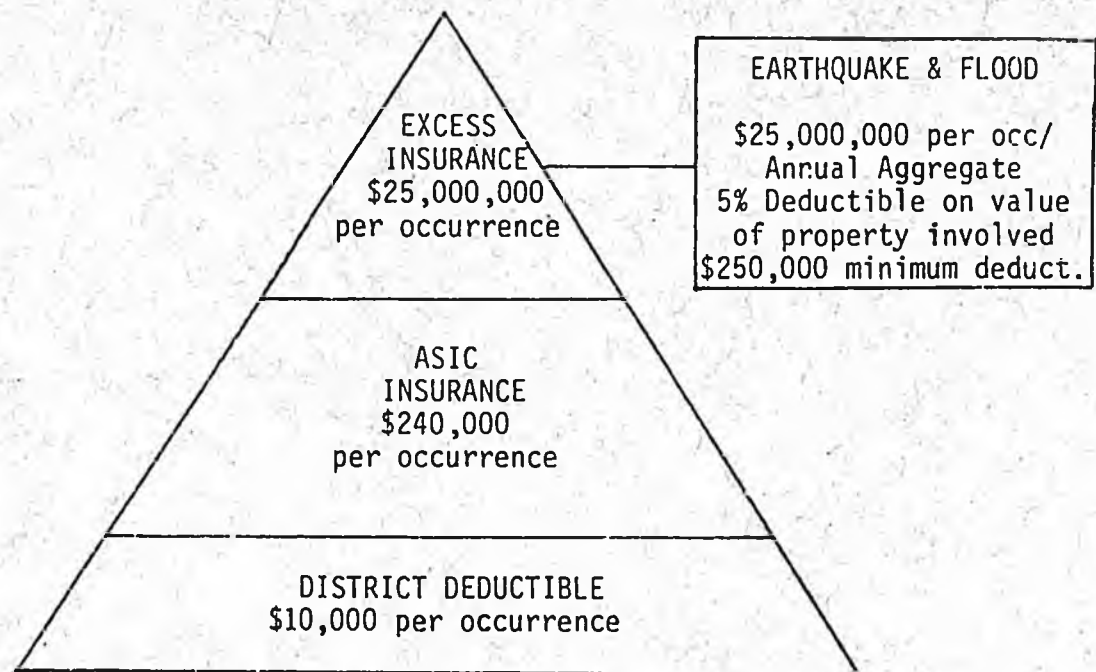


ALASKA SCHOOLS INSURANCE CO.

316 W. 11th St. • Juneau, Alaska 99801 • (907) 586-3635

Twenty-nine school districts have joined together through the Association of Alaska School Boards (AASB) to form a captive insurance company, the Alaska Schools Insurance Company (ASIC) to provide property insurance. The program is open to all school districts which are members of AASB. ASIC's first year of operation began July 1, 1986.

Based on a pooling concept, ASIC provides a first layer of coverage with a limit of \$240,000 per occurrence and a \$10,000 deductible. Excess insurance beyond the overall \$250,000 ASIC limit provides a total coverage of \$25,000,000 per occurrence per district. Earthquake and Flood coverage is provided solely through the excess insurance policy. The diagram below illustrates the structure of the ASIC program.



ASIC was formed as a captive insurance company through the state of Vermont since there was no enabling legislation in place in Alaska that would allow school districts to form a more traditional insurance pool here. Such legislation has since been passed and ASIC will seriously consider forming a pool under the laws of Alaska.

ASIC is currently investigating the area of liability insurance, to determine 1) if there is a documented need for an additional source of liability insurance for districts, 2) if there are benefits that can be derived through a group program that cannot be realized through other insurance sources currently available, 3) the most advantageous arrangement to provide such coverage if the answer to the first two conditions is yes.



ALASKA SCHOOLS INSURANCE COMPANY

MEMBER DISTRICTS

Adak
Alaska Gateway
Aleutian Region
Annette Island
Chugach
Copper River
Delta Greely
Galena
Hydaburg
Iditarod
Kake
Kashunamiut
King Cove
Lake & Peninsula
Lower Kuskokwim
Lower Yukon
Nenana
Northwest Arctic
Pelican
Pribilof
Railbelt
St. Mary's
Sand Point
Southwest Region
Tanana
Unalaska
Yukon Flats
Yukon/Koyukuk
Yupit

TOTAL PROPERTY VALUES COVERED: \$755,194,945

TOTAL ASIC PREMIUM: \$ 1,490,472

1986-87 RATE: \$.75/\$100 of value

Rate Breakout: ASIC Coverage \$.10/\$100 of value
ASIC Capitalization \$.10/\$100 of value
Excess Coverage \$.55/\$100 of value

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
DIVISION OF INSURANCE
P. O. BOX D
JUNEAU, ALASKA 99811

ORDER 86-3

**Re: Revised Workers' Compensation Insurance Rates Effective
January 1, 1987.**

**To: The National Council on Compensation Insurance.
All Insurers Authorized to Write Workers' Compensation
Insurance in the State of Alaska.
All Interested Parties.**

The Hearing Officer for the Director of Insurance does hereby find as follows:

Background.

1. On November 3, 1986, the Division of Insurance received a filing from the National Council on Compensation Insurance (hereafter NCCI) dated October 31, 1986, which was supplemented with additional data on November 11, 1986. The filing proposed a rate change for workers' compensation insurance rates effective on January 1, 1987 for all new and renewal business.
2. NCCI is a national rating organization licensed by the State of Alaska pursuant to AS 21.39.060. It does statistical compilation of data, including premium, payroll, loss and expense data, on behalf of its member and subscriber insurers. It makes rate and policy form filings with the State of Alaska on behalf of its member and subscriber insurers.

3. In view of the significance of the impact of the proposed filing on the Alaska economy, a hearing was deemed necessary to afford the public an opportunity to present its views on the filing and to receive any information that would tend to place in question any of the data or assumptions underlying the proposed filing. Notice was prepared and mailed to all insurers licensed in Alaska and to the Alaska Chapter of the Associated General Contractors. In addition, notice was published in the Anchorage Daily News and in the Alaska Journal of Commerce. The hearing was held at the Federal Building in Anchorage on November 24 & 25, 1986.

The Proposed Filing

4. The overall average increase in statewide premium level resulting from implementation of the proposed filing is an ~~increase of 14.3%~~. The components of the increase are as follows:

- increase due to experience..... +13.3%
- reduction for change in premium tax..... -00.2%
- increase due to change in trending for medical losses..... +01.7%
- reduction to offset previous increase of the workers compensation pool surcharge from 10% to 20% resulting in a reduced subsidy of pool business by that business in the voluntary market..... -00.6%

5. The overall average is further broken down into four (4) major industry groupings, each with a different impact from the filing reflecting that groups' contribution to the loss level. Within the groups, individual classifications can move by $\pm 25\%$ from the group overall indication, further reflecting the particular experience of the individual classification. The four groups, the indicated rate change by group, and the range of rate movement for classifications in each group are:

GROUP	IMPACT	RANGE of IMPACT
Manufacturing	+1.8%	+27.0% to -23.0%
Contracting	+20.5%	+46.0% to -4.0%
Oil & Gas	+7.4%	+33.0% to -17.0%
All Other	+13.3%	+39.0% to -11.0%

6. There are a total of 546 classifications used in the NCCI classification manual. Of the 546 classifications, 434 classifications had some payroll for the period used to determine classification relativity in Alaska. Of that 434 classifications, 116 classifications had more than \$10 million of payroll in Alaska. The total numbers of classifications in the manual by industry group are:

GROUP	TOTAL NCCI CLASSES	SOME ALASKA PAYROLL	+10 MILLION ALASKA PAYROLL
Manufacturing	294.	102.	7
Contracting	67.	63.	27
Oil & Gas	11.	11.	7
All Other	174.	158.	75

7. The effect of the change proposal on some classes is significant. This can be seen from the listing of classifications in Attachment #1 in which the impact of this filing is noted. The classifications listed in Attachment #1, each had Alaska payroll in excess of \$10,000,000 during the period beginning April 1, 1981 and ending March 31, 1984.
8. The filing is not unusual in terms of past filings or in the methodology utilized. The filing follows methods that have been used in the past in this state and found to be acceptable in past reviews. It is, in a sense, routine.

History.

9. Since 1974, the Division of Insurance, Market Surveillance Section has closely monitored workers' compensation insurance experience of insurers writing that line of insurance in Alaska. The purpose was to measure competition and to develop an independent base with which to measure the proposals of NCCI. By applying Division of Insurance devised formulas and tests to this base information, which is limited in its sophistication, the Division of Insurance has generally been able to predict rate changes within two or three percent of the actual proposal and to do so about six months before a filing is proposed. Since this approach does lack sophistication and is not accurate to

the degree desirable for ratemaking purposes, the results of these tests have not been widely publicized. One concern is that the tests done by the Division of Insurance should not be available for potential use by insurers as part of the support for rate change proposals.

10. In July 1986, the Alaska Department of Labor released a publication titled "Occupational Injury and Illness Information - Alaska 1984" which contains data of interest to those concerned with the cost level for workers' compensation insurance. The publication notes that Alaska has one of the highest rates in the nation for industrial illness and injury. Not surprisingly, the publication notes a number of highlights which tend to provide some clues concerning why the rating structure is responding in the proposed manner. These include:

- The Alaska Division of Workers' Compensation processed 11,398 time loss claims for 1984, an increase of 5% over 1983.
- The construction industry leads all others in the number of reported time loss cases (2,680) accounting for 23.5% of all cases.
- Craftsmen, laborers, and operatives (excluding transport) are consistently the leading occupational groups for time loss cases, with nearly two-thirds ($\frac{2}{3}$) of all cases.
- Sprains and strains continue to be the leading nature of injury (48.3% of the total).
- The back is historically the most frequently injured part of the body and is involved in one-fourth ($\frac{1}{4}$) of all time loss cases. Strains and sprains are the most common result of back injuries.

Reasons for why Alaska has become an increasingly dangerous place to work as compared to other areas is not fully understood. The publication reports incidence rates of recordable occupational injuries and illnesses by group as follows:

- 9.7 cases per 100 workers in Alaska;
- 43.0 cases per 100 workers in Lumber and Wood Products;
- 25.0 cases per 100 workers in Food and Kindred Products;
- 24.2 cases per 100 workers in Trucking and Warehousing;
- 22.6 cases per 100 workers in Building Materials. Retail;
- 22.0 cases per 100 workers in Oil & Gas Field Services; and,
- 17.7 cases per 100 workers in Building Construction;

11. Utilizing the process noted in § 9, it was noted in June 1986 that there was a likelihood of a significant filing to be effective on January 1, 1987. At that time the Market Surveillance Section concluded that a 21.5% overall premium level increase would be needed and that due to data anomalies the true need was probably closer to 30%. The data anomalies referred to, are the impacts of reserve strengthening attributable to prior years. In effect, we have either overstated the need by more than 7 percent or conversely, NCCI has filed a filing that is insufficient to meet needs by at least 7 percent.
12. During testimony given by NCCI, their actuary admitted that the 20.5% indication for the Contracting group should actually have been 26.6%. The 26.6% indication was tempered with the lower 20.5% indication because of some concern by NCCI that the data producing the higher result, might somehow be a ripple that would drive the rates higher than necessary.

Ratemaking.

13. The ratemaking process is generally a mathematically based exercise that, while very complex, is not mysterious. In 1981, NCCI published a 12 page booklet titled, "Ratemaking...The Pricing of Workers' Compensation Insurance". It would not be practical to recite much of the data contained in that document, though the temptation is great. It is an excellent primer on just what goes into the making of workers' compensation insurance rates, and it is of such value that it accompanies this order as Attachment #2.

Role of Division of Insurance.

14. When the Division of Insurance receives an insurance rate filing from an insurance company or a rating organization such as NCCI, it does so under AS 21.39.040 which provides statutory standing for the filer, review time limitations for the state, and references standards used to determine whether a filing may be approved or disapproved. The standards found in AS 21.39.030 provide that the rates shall not be excessive, shall not be inadequate, and shall not be unfairly

discriminatory. NCCI has not made a substantial departure from its past methodology in this filing, so the methodology is one that has been accepted and tested in the past as well as at this juncture. The documentation supports the contention that the current rate structure is inadequate. In fact the independent data developed by the Division of Insurance suggests that the proposed level itself may not be sufficient to meet expected losses.

15. The standards set forth in the rate law (AS 21.39) do not provide for the application of political or economic considerations when reviewing a rate filing. The law was specifically designed to avoid just that occurrence. Viewing it from these considerations, the proposed filing could not have come at a worse time. The economy is currently devastated by the instability of oil prices and is experiencing an apparent "bust." Politically, there are the usual unknowns experienced when the administration of state government changes. These place pressures on such a filing which while recognized, can not be considered under the law.
16. The Division of Insurance does not influence the benefits available under the Alaska Workers' Compensation Act. Those are established by the legislature and administered by the Alaska Workers' Compensation Board (hereafter Board). The Board generally becomes involved only with the specific request of the claimant, but the Division of Insurance can not. There is one additional party regularly appearing on the scene, again via the claimant, and that is the court system.
17. The Division of Insurance does not deal with individual consumer complaints involving workers' compensation insurance. These are all referred to the Board. The Division of Insurance can deal with trade practices when a series of abuses become known to the Division. To this end there is a cooperative effort currently under way between the Division of Workers' Compensation in the Department of Labor (administrative arm of the Board) and the Division of insurance.
18. When the Legislature addresses an issue relating to workers' compensation insurance, the role of the Division of Insurance is to attempt, through NCCI, to determine the price impact of the proposed legislation. The Division of Insurance does not and should not take an

advocacy posture as respects changes to the benefit structure in the Alaska Workers' Compensation Act.

19. The Division of Insurance does have a strong role in the efficiency of operation of the rating systems utilized by insurers writing workers' compensation insurance. It has a strong interest in factors that affect the data base from which rates are derived. It is concerned with issues that can influence the accuracy of the data base underlying the rate structure. Because of these interests and concerns, the Division of Insurance wants to:

- assure the proper reporting and gathering of payroll data;
- assure the proper and equitable application of the filed classification system; and,
- assure the proper conduct of persons writing coverage for an employers workers' compensation liability.

Public Frustration with System

20. During the public hearing held as noted in § 3, witnesses testified to some of the frustrations experienced. In many cases, the Division of Insurance does not have jurisdiction to address the kind of problem described. Numerous issues were discussed in the hearing and more in correspondence and in telephonic communications. Many times, the extent of recognition of these problems is the stereotypical comment, "it's not my job." While to a great extent that may be true of the issues witnesses have brought to us in this hearing, we would prefer to at least describe the issues for the benefit of those who may be in a position to address them or to dismiss them.

21. Workers' Compensation Insurance costs are often a very large part of employer cost. When a problem arises, it is often difficult for an employer to identify a source of assistance. Sometimes the Division of Insurance can help, sometimes the Division of Workers' Compensation can help, but all too often the assistance sought is beyond the capabilities or jurisdiction of either agency. This fosters a sense of frustration in the employer. Examples are:

- . trying to determine whether an individual is an independent

contractor or will be held to be an employee;

□ trying to have something done about a claimant who is known to the employer to be malingering or abusing the system; etc.

22. Contractors are stuck in a particularly difficult situation because they often bid work to be done in a period for which the workers' compensation insurance rate is not yet known. If there is a dramatic unanticipated change in the rate, the impact can be destructive. Other industries are similarly affected but none so broadly as contracting. In the current proposal, some contracting rates are proposed to rise as much as 46.0%.
23. Fraud does occur in this kind of insurance and is one of the things that tend to frustrate employers who see the system abused, but prosecution of the cases is difficult to stimulate. The Division of Insurance has completed investigation on four cases that are currently awaiting prosecution, and according to the Division's Investigator, the total amount that is alleged to have been improperly acquired is about \$380,000. Vigorous prosecution and publication of such fraud cases should help to act as a deterrent to such activity.
24. Testimony from several witnesses addressed the disparity between rates charged in Alaska and in other jurisdictions. They face competition from persons in those jurisdictions who either do not elect to comply with Alaska law or believe incorrectly that their existing policy will extend to provide Alaska benefits. The advantage that this can give to the noncomplying contractor can be profound.
25. Those operators who operate with injury incident rates far below their peers are to a great extent subsidizing those operators who for whatever reasons have the losses. That, of course, is part of the principle of insurance, the spreading of the losses of the few amongst the many. When a kind of insurance is as expensive as is workers' compensation insurance has come to be in Alaska, the usual explanation of the "principles of insurance" or "the law of large numbers" merely adds fuel to the fire no matter how true. The question has been posed, why does the state continue to allow the bad operator to continue to hurt people and continue to dig into other employers' pockets. To a small degree, insurer selection or underwriting tends to force such employers into the assigned risk

plan, but that market too is subsidized by all other employers. The current level of subsidy is about 13%.

26. The most persistent complaint from contractors is that it is imperative that they be given adequate notice of the changes. The definition of adequate notice was on the order of 6 to 12 months. The fact is, that there has never been more notice of a change than in the current instance. Notice was posted in early November. Typically the rates in the past have changed with less than 30 days notice. The change applies to new policies and to existing policies only when they renew which could be as late as December 31, 1987.

The Division of Insurance has also advised the NCCI that future filings would likewise require a minimum of 60 days of lead time rather than rely on the 15 days stated in the statute for review

27. A common thread throughout the testimony was that since the Alaska contractor has to tighten his belt the insurance companies should do likewise. However, the workers compensation insurance line is one that has given insurers particular grief in this state over the years and experience in recent years has been dismal. Alaska is currently being subsidized by the results of other lines and that does not attract new carriers in the marketplace or encourage those already there to continue previous levels of activity. One support for to this comment is the increase in pool writings by over 300% in one year. This view tends to look upon insurers as the cause or the "illness" when in fact it is merely the symptom or reflection of the underlying problem.
28. When a rate increase such as this goes into effect, it applies to new and renewal business as has already been noted. This fact itself offers both pain for some and relief for others depending on when the particular employers' policy expires and whether the change is an increase or a decrease. It impacts the cost effectiveness of an employer depending at what point he is bidding a job and whether his workers' compensation insurance costs for the period bid are known when bidding. The cure for that may be worse than the "illness" it intends to cure. One solution would be to have the rates all change at the same time. In other words a rate change would apply to in-force policies. This would be cumbersome. It would probably require a law

change. Part of the solution might be to have all policies expire on the same date. That too would require legislation.

29. A portion of the testimony leveled criticism at the Board and at the courts for its "liberal" view of the Act. Many felt that the system is out of balance and is too one-sided favoring the claimant.
30. A substantial portion of the loss dollar is directly attributable to medical care. There has been some concern over the sometimes experienced reluctance by physicians to issue return to work notices. The reluctance is due in part to fear that the action may generate a charge of malpractice thus intensifying an already difficult situation for the physician. In other cases, the expression "ambulance chaser" has been used with some charity.
31. One witness asserted that the enforcement efforts of the Division of Workers' Compensation concerning compliance with the Act are inadequate, contending that that effort ought to be at least tripled.
32. The legal expense component of the workers' compensation insurance premium has grown over the years beyond the level anticipated. Claimants are growing increasingly litigious in a system that is intended to be no-fault. Why this is felt to be necessary, should be examined before it gets out of hand.
33. Several witnesses felt that the rehabilitation system is cumbersome, ineffectual and very expensive.

Conclusions

34. Most of the testimony brought to the Division of Insurance was not to the point of things that could be considered. While the participants to the hearing were uniform as to the effect of the proposal, none were able to offer reasonable refutation of the underlying premise supporting the filing, namely that the increase is necessary to meet expected losses arising from workers' compensation insurance liability in this state.
35. There were repeated requests for delay but nothing on which to

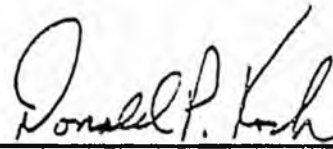
support the granting of such a request, that meshes with the standards that the Division of Insurance must use to test the propriety of the proposal; the tests being that the rates shall not be inadequate and the rates shall not be excessive. It is recognized that the proposal will not bode well for those impacted with substantial upward increases.

36. Arguments were made concerning the classification system of the NCCI, labeling it as arbitrary. The system is a key element to the insurance system in this state, and in most other states. It is not perfect but it is responsive. It has been under close scrutiny by the Alaska Division of Insurance since the issue of Order 76-1 on February 17, 1976. There is a good deal of fine tuning going on and Alaska has had a hand in that process. These arguments are rejected as uninformed and unsupported. In 1982, NCCI published a 12 page booklet titled, "**Classification is Fundamental to Workers' Compensation Insurance.**" Again, this publication does a much better job of explaining the classification system, its reasons for existence, and its underlying logic, than this hearing officer can produce. For this reason, it accompanies this order as Attachment #3.
37. Rates filed by the NCCI should be as nearly reflective of needed premium levels as possible. The review of the filing done by the Division of Insurance and the separate review of indications support the filing as made.

The Hearing Officer for the Director of Insurance does Hereby Recommend Adoption of the Following Order:

- A. The rates promulgated by NCCI to be effective on January 1, 1987 are not excessive and for that reason are approved.
- B. A copy of this order is to be sent to the Governor of the State of Alaska, to the Alaska Workers' Compensation Board, to the legislative oversight committees for issues relating to workers' compensation (the Labor and Commerce Committees of the House and the Senate), to the National Council on Compensation Insurance, and to other interested parties.

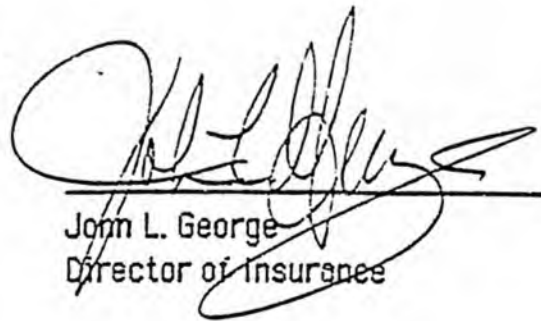
Done this 16th day of December, 1986.



Donald P. Koch
Hearing Officer

The Director of Insurance Hereby adopts the order of the Hearing Officer and approves the October 31, 1986 filing of the NCCI for workers' compensation insurance rates effective on January 1, 1987.

Done this 16th day of December, 1986.



John L. George
Director of Insurance

ATTACHMENT #1

IMPACT OF RATE FILING ON SPECIFIED CLASSIFICATIONS

7422 Aircraft-Air Taxi-Flying Crew	+16.0%	7540 Elec Light & Power Co-ops Rural	+16.4%
7431 Aircraft-Commuter-Flying Crew	-11.0%	7538 Elec Light or Power Line Constr	+27.6%
7414 Aircraft-Ground Crew	+3.6%	9519 Electrical Appliance Install, Rpr	+14.5%
7405 Aircraft-Scheduled-Flying Crew	-11.0%	5190 Electrical Wiring in Buildings	+37.6%
7421 Aircraft-Trans. of Employees	-11.0%	8610 Engineers or Architects Consulting	-7.1%
7605 Alarm Systems Install & Repair	+31.2%	6217 Excavation NOC	+26.8%
4511 Analytical Chemists	+33.2%	7704 Firemen	+5.6%
8820 Attorney	-10.6%	8044 Furniture Stores	+6.0%
8387 Auto Accessories Service Station	+8.1%	9403 Garbage Collectors	+9.2%
8393 Auto Body Repairing	+24.7%	6319 Gas Mains or Connections Const.	-3.9%
8391 Auto Garages and Repair Shops	+36.6%	8350 Gasoline or Oil Dealers	+39.0%
8748 Automobile Salesmen	-1.8%	8607 Geophysical Exploration NOC	+35.4%
2003 Bakeries	+26.7%	8606 Geophysical Exploration Seismic	+37.1%
9586 Barber Shops, Beauty Parlors	+5.7%	8010 Hardware Stores	+39.0%
7390 Beer or Ale Dealers	+39.0%	9040 Hospital, All Other	+37.7%
9014 Buildings, Oper. by Contrtr	+13.5%	8833 Hospital, Professional	+13.7%
9015 Buildings, Oper. by Ownr/Lessee	+34.4%	9052 Hotels	+14.3%
7382 Bus or Taxicab Companies	+38.9%	9058 Hotels-Restaurant Employees	+23.9%
8385 Bus or Taxicab Garage	+9.2%	5479 Insulation Work	+30.3%
2111 Canneries	+25.4%	5057 Iron or Steel Erection NOC	+42.5%
5645 Carpentry Const-Private Resid.	+44.8%	8013 Jewelry Stores	+5.6%
5651 Carpentry Const-Priv. Res. 3 Stor.	+4.0%	8755 Labor Unions	-5.7%
5403 Carpentry NOC	+7.3%	2702 Logging	+11.0%
2803 Carpentry Shop Only	+27.0%	8232 Lumber Yards, All Othr Employees	+39.0%
8810 Clerical Office Employees	-10.6%	8058 Lumber Yards, Store Employees	+24.4%
8008 Clothing or Dry Goods Stores	+0.7%	3632 Machine Shops	+27.0%
9061 Clubs NOC	+14.2%	8107 Machinery Dirs NOC Store/Yard	+23.4%
1005 Coal Mining Surface	-9.8%	5022 Masonry NOC	+12.8%
9101 Colleges, Schools-All Other	+11.5%	3724 Millwright	+45.9%
8868 Colleges, Schools-Professional	0.0%	1165 Mining NOC Surface	+0.7%
9078 Commissary	+38.9%	9410 Municipal or State Employees	+36.2%
5213 Concrete Construction NOC	+37.1%	7502 Natural Gas Companies	+38.8%
5221 Concrete Flrs, Drivwys, Sidw/lks	+16.8%	4304 Newspaper Publishing	+11.2%
6325 Conduit Construction	+4.6%	8829 Nursing Homes	+38.9%
5606 Contractors Executive Supvsrs	+22.7%	5191 Office Machine/Appliance Install	+15.8%
8227 Contractors Permanent Yard	-4.0%	1320 Oil or Gas Lease Operators	-5.3%
8039 Department Stores Retail	+11.0%	6216 Oil or Gas Lease Work by Contr	+33.0%
6204 Drilling NOC	+9.9%	6233 Oil or Gas Pipeline Construction	+19.5%
7380 Drivers, Chauffeurs & Helpers	+38.8%	7515 Oil or Gas Pipeline Operation	-4.8%
7539 Electric Light & Power Co NOC	+7.4%	6206 Oil or Gar Well Cementing	+6.9%