ALASKA LEGISLATURE COMMITTEE FILES, 1989-1990 8672
5765 HOUSE JUDICIARY 169

sicians, 50 Wash.L.Rev. 385 (1975) (hereinafter "Comment, *Hospital Responsibility*").

Jackson concedes that Dr. Power was an independent contractor; however, he asserts that Alaska's law of *respondeat superior* mandates a result different than that which would be reached under the general rule.[5] Jackson argues that our decision in *Fruit v. Schreiner*, 502 P.2d 133 (Alaska 1972), establishes that the law of "vicarious legal responsibility" in Alaska is "enterprise liability." Thus, he contends, if the enterprise impacts society and the negligent act occurred during an activity performed for the benefit or in the interest of the enterprise, the enterprise is liable.

[3] Jackson's argument proves unpersuasive. First, Jackson's interpretation of *Fruit* is flawed. A close reading of that case shows that we did not view "enterprise liability" as a separate theory of liability or a distinct cause of action. Rather, enterprise liability was seen as one of two widely accepted theories used by courts to justify imposition of vicarious liability in an established employer/employee context. *Id.* at 138–39. As was noted in *Fruit*:

> [T]he "enterprise" theory ... finds liability whenever the enterprise of the employer would have benefited by the context of the act of the *employee* but for the unfortunate injury.
>
> ....
>
> The rule of *respondeat superior* however, ... is *limited* to requiring an enterprise to bear the loss incurred as a result of the *employee's* negligence. The acts of the *employee* need be so connected to his employment as to justify requiring that the employer bear that loss.

Id. at 140–41 (emphasis added) (footnotes omitted). *See generally* Morris, *Enterprise Liability and the Actuarial Process—the Insignificance of Foresight*, 70 Yale L.J. 554 (1961).

Additionally, our decisions since *Fruit* show that we have applied the theory of *respondeat superior* only in an employer/employee context, unless one of the well established exceptions to that rule exists. *See, Parker Drilling v. O'Neill*, 674 P.2d 770, 775 (Alaska 1983); *Williams v. Alyeska Pipeline Service Co.*, 650 P.2d 343, 349 (Alaska 1982); *Hammond v. Bechtel Inc.*, 606 P.2d 1269, 1273 (Alaska 1980); *Barton v. Lund*, 563 P.2d 875, 876 (Alaska 1977); *Luth v. Rogers & Babler Construction*, 507 P.2d 761, 763–64 (Alaska 1973). Jackson's theory presents no such exception.

Finally, the cases from other jurisdictions cited by Jackson provide little support for his theory; those cases deal only with theories of apparent agency or corporate negligence. Moreover, although at least two courts appear to have implicitly indicated a willingness to recognize a theory of enterprise liability, *see Alden v. Providence Hospital*, 382 F.2d 163, 166 (D.C. Cir.1967); *Adamski v. Tacoma General Hospital*, 20 Wash.App. 98, 579 P.2d 970, 977 & n. 5 (1978), to date, no court has explicitly embraced that concept.[6]

In short, Jackson's theory of enterprise liability is not yet the law in Alaska.

V

Jackson next argues that the trial court erred in holding that genuine issues of material fact prevented it from granting summary judgment on his theory of apparent authority.

5. The trial court decided the issue of the applicability of enterprise liability as a matter of law. We scrutinize questions of law under a *de novo* or independent judgment standard of review. *Hicklin v. Orbeck*, 565 P.2d 159, 163 n. 6 (Alaska 1977), *rev'd on other grounds*, 437 U.S. 518, 98 S.Ct. 2482, 57 L.Ed.2d 397 (1978). When reviewing a question of law, it is our "duty to adopt the rule of law that is most persuasive in light of precedent, reason and policy." *Guin v. Ha*, 591 P.2d 1281, 1284 n. 6 (Alaska 1979).

6. Some commentators have suggested an enterprise tort doctrine as a basis for imposing liability for any tort occurring as part of the hospital enterprise. *See* Southwick, *Hospital Liability: Two Theories Have Been Merged*, 4 J. Legal Med. 1, 3–5 (1983); Comment, *Hospital Responsibility*, *supra* at 418–19.

Although we have recognized the doctrine of apparent authority in other contexts, *see City of Delta Junction v. Mack Trucks*, 670 P.2d 1128, 1129-30 (Alaska 1983) (national distributor and local franchise), *Perkins v. Willacy*, 431 P.2d 141, 142 (Alaska 1967) (husband and wife), this is the first time we have been asked to apply this doctrine to a hospital-independent contractor/physician relationship.

Cases from other jurisdictions show a strong trend toward liability against hospitals that permit or encourage patients to believe that independent contractor/physicians are, in fact, authorized agents of the hospitals.[7] These courts have held hospitals vicariously liable under a doctrine labeled either "ostensible" or "apparent" agency or "agency by estoppel." *See Porubiansky v. Emory University*, 156 Ga. App. 602, 275 S.E.2d 163, 168 (1981); *Paintsville Hospital v. Rose*, 683 S.W.2d 255, 257 (Ky.1985); *Mehlman v. Powell*, 378 A.2d 1121 (Md.1977); *Greue v. Mt. Clemens General Hospital*, 404 Mich. 240, 273 N.W.2d 429, 432-33 (1978); *Arthur v. St. Peters Hospital*, 169 N.J.Super. 575, 405 A.2d 443 (1979); *Hannola v. City of Lakewood*, 68 Ohio App.2d 61, 426 N.E.2d 1187, 1192 (1980); *Weldon*, 709 P.2d at 1060; *Themins v. Emanuel Lutheran Charity Bd.*, 54 Or.App. 901, 637 P.2d 155, 158-59 (1982); *Adamski v. Tacoma General Hospital*, 20 Wash.App. 98, 579 P.2d 970, 977 (1978); *see generally* Janulis & Hornstein, *supra* at 696–702. Although courts and commentators often use these terms interchangeably, they are not theoretically identical.

[4] The "ostensible" or "apparent" agency theory is based on Section 429 of the Restatement (Second) of Torts (1965), which provides:

> One who employs an independent contractor to perform services for another which are accepted in the reasonable belief that the services are being rendered by the employer or by his servants, is subject to liability for physical harm caused by the negligence of the contractor in supplying such services, to the same extent as though the employer were supplying them himself or by his servants.

Two factors are relevant to a finding of ostensible agency: (1) whether the patient looks to the institution, rather than the individual physician, for care; and (2) whether the hospital "holds out" the physician as its employee. *Simmons v. St. Clair Memorial Hospital*, 332 Pa.Super. 444, 481 A.2d 870, 874 (1984); *see also Irving v. Doctors Hospital of Lake Worth*, 415 So.2d 55, 60–61 (Fla.App.1982); *Smith v. St. Francis Hospital*, 676 P.2d 279, 282 (Okla.App.1984).

[5] "Agency by estoppel," in contrast, is predicated on the arguably stricter standard of the Restatement (Second) of Agency § 267 (1958). Section 267 provides:

> One who represents that another is his servant or agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.

Under this theory, there must be actual reliance upon the representations of the principal by the person injured. *Mehlman*, 378 A.2d at 1123.

> Thus, theoretically, there need be no causal relationship between the principal's conduct and the plaintiff's reliance to warrant a conclusion of ostensible agency; such a causal relationship and such a change of position, however, is the essence of estoppel to deny agency.

Janulis & Hornstein, *supra* at 697.

[6] Jackson, in essence, asks us to adopt a rule of ostensible agency. FMH,

7. The only exception to this modern trend of which we are aware is *Greene v. Rogers*, 147 Ill.App.3d 1009, 101 Ill.Dec. 543, 498 N.E.2d 867 (1986). In *Greene*, the court specifically refused to apply apparent agency to a hospital-emergency room doctor relationship because "[t]he absence of the power to control the decision-making of the emergency room physician demands that the independent relationship between hospital and emergency room physician be recognized." *Id.* 101 Ill.Dec. at 547, 498 N.E.2d at 871. We view *Greene* as an aberration dependent upon reasoning which is not particularly persuasive.

on the other hand, requests that we follow *Greene* and refuse to apply this doctrine in the hospital-physician context or, alternatively, that we adopt a rule which is essentially estoppel by agency. Although we find nothing antithetical about applying the doctrine of apparent authority to a hospital-independent contractor/physician relationship, we perceive no reason to adopt a special rule in this area. We believe that traditional rules of apparent authority provide sufficient guidelines.

In *City of Delta Junction*, we defined the doctrine of apparent authority in Alaska as follows:

> Apparent authority to do an act is created as to third persons by written or spoken word or any other conduct of the principal which, reasonably interpreted, causes the third person to believe that the principal consents to have the act done on his behalf by the person purporting to act for him.

670 P.2d at 1130 (quoting Restatement (Second) of Agency § 27, at 103 (1958)). We went on to emphasize that it is the *principal's* conduct that gives rise to his liability and not the conduct of the alleged agent; "one dealing with an alleged agent must prove that the principal was responsible for the appearance of authority, by doing something or permitting the alleged agent to do something that led others, including the plaintiff, to believe that the agent had the authority he purported to have." *Id.* (quoting W. Seavy, *Handbook of The Law of Agency* § 8, at 13 (1964)).

Relying on *City of Delta Junction*, the trial court held that existing factual disputes required Jackson to submit his apparent authority theory to the jury. When reviewing the denial of a motion for summary judgment, we must determine whether genuine issues of material fact exist, and if not, whether the moving party is entitled to judgment as a matter of law. Alaska R.Civ.P. 56(c); *Shatting v. Dillingham City School District*, 617 P.2d 9, 11 (Alaska 1980). In reaching this decision we must draw all reasonable inferences in favor of the non-moving party and against the movant. *Id.*

Drawing all reasonable inferences in the light most favorable to FMH, the record shows the following: at the time of Jackson's accident, FMH was the only civilian hospital north of Anchorage providing emergency room services in Alaska. Two road signs in Fairbanks note the location of the hospital. However, neither of these signs specifically refer to the existence of emergency room services. The signs were not constructed or situated by FMH. In fact, FMH does no advertising at all.

From the time of its establishment in 1972, FMH has never staffed its emergency room with its own physician employees, but has always relied upon local physicians to provide that service. Prior to the formation of ERI in 1977, FMH's emergency room was serviced by three local clinics, each providing one physician on a nightly basis. After 1977, ERI provided one physician on a nightly basis who worked a 14-hour graveyard shift (6:00 p.m. to 8:00 a.m.).[8] While on duty in the emergency room, the ERI physician was "in charge" and no FMH personnel were responsible for either scheduling or monitoring the emergency room physicians. No contractual arrangement existed between FMH and ERI for the provision of emergency room physicians.

In apparent non-life threatening situations the first person an incoming patient sees at the emergency room is the admissions clerk. Immediately adjacent to the clerk's desk is a sign which indicated that physicians from ERI were working in the emergency room. Although the exact state of Jackson's awareness is not entirely clear, there is evidence suggesting that he was admitted in a conscious state.[9] Ne-

8. The clinics continued to provide an additional physician for the graveyard shift on a rotation basis.

9. Jackson testified at his deposition that he recalled being placed in the helicopter but had no recollection of being removed from it, being taken to FMH or of meeting the doctor who treated him. On the other hand, the medical records indicate that Jackson appeared to be neurologically stable, completely oriented and gave no indication that he was unconscious or in distress. Muremer, at his deposition, Dr.

ther Jackson nor his mother selected FMH as the place of treatment nor Dr. Power as Jackson's physician.

[7, 8] From the above, a jury could conclude that FMH held itself out as providing emergency care services to the public. A jury could also find that Jackson reasonably believed that Dr. Power was employed by the hospital to deliver emergency room service. It is also possible, however, that a jury could find to the contrary.[10]

Unless the evidence allows but one inference, the question of apparent authority is one of fact for the jury. *City of Delta Junction*, 670 P.2d at 1131; *Themins*, 637 P.2d at 159; *Adamski*, 579 P.2d at 978. In the case at bar, the record is not susceptible to a single inference. Thus, the trial court properly denied summary judgment on this issue.

VI

Jackson's final point is that the trial court erred in refusing to rule, as a matter of law, that FMH, as a general acute care hospital, has a non-delegable duty to provide non-negligent physician care in its emergency room. In essence, Jackson's position is that when a hospital undertakes to operate an emergency room as an integral part of its health care enterprise, public policy dictates that it not be allowed to insulate itself from liability by shunting that responsibility onto another.

FMH, on the other hand, argues that a hospital does not have a non-delegable duty to guarantee safe treatment in its emergency room. Physicians, not hospitals, FMH asserts, have a duty to practice medicine non-negligently. Thus, according to FMH, a hospital cannot be held to have delegated away a duty it never had.

The trial court ruled that "[t]here cannot be a non-delegable duty if there is no contractual relationship." Since it was unclear from the evidence whether or not there was any contractual relationship between ERI and FMH, the court denied Jackson's motion for summary judgment. Initially, we note the trial court's erroneous characterization of the issue. By holding that there can be no "non-delegable duty if there is no contractual relationship," the court confused the question of the existence of a duty with the issue of whether a duty is non-delegable. The flaw in this reasoning is self-evident. As FMH points out, a party cannot be held to have delegated away a duty it never had. Thus, the threshold question is whether FMH had a duty to provide emergency room care. Only if it did, is it necessary to determine what that duty entailed.

[9] FMH is licensed as a "general acute care hospital."[11] As such, it is required to comply with state regulations designed to promote "safe and adequate treatment of individuals in hospitals in the interest of public health, safety and welfare." AS 18.-20.060. These regulations provided, at the time of Jackson's accident, that an acute care hospital *shall* "insure that a physician is available to respond to an emergency at all times." Former 7 AAC 12.110(c)(2).[12] Thus, at a minimum, the law imposed a duty on FMH to provide emergency care physicians on a 24-hour basis.

FMH, however, voluntarily assumed a much broader duty. At the time of Jackson's accident, FMH was accredited by the

Power testified that "Jackson was talking" and "completely oriented."

10. In this regard, we agree with the weight of authority that application of apparent authority in the hospital/emergency room physician situation does not require an express representation to the patient that the treating physician is an employee of the hospital. Nor is direct testimony as to reliance required absent evidence that the patient knew or should have known that the treating physician was not a hospital employee when the treatment was rendered. *See* cases cited *supra* p. 1380.

11. A general acute care hospital is a "facility which provides hospitalization for inpatient medical care of acute illness or injury and obstetric care." 7 AAC 12.100.

12. In 1983, this regulation was amended to provide that "[a] general acute care hospital *must* provide ... [among other services not relevant here] emergency care services." 7 AAC 12.105 (emphasis added).

Joint Committee on the Accreditation of Hospitals (JCAH).[13] In order to receive and maintain accreditation,[14] FMH had to comply with the JCAH's standards promulgated in the *Accreditations Manual For Hospitals, Emergency Services.* Standard I mandates that all accredited hospitals implement a well defined plan for emergency care based on community need and the capability of the hospital. The JCAH standards also mandate, among other things, that: (1) FMH's emergency room be directed by a physician member of the active medical staff (Standard II); (2) FMH's emergency room be integrated with other units and departments of the hospital (Standard III); (3) that emergency care be guided by written policies and procedures; and (4) that the quality of care be continually reviewed, evaluated and assured through establishment of quality control mechanisms (Standard V).

Additionally, FMH's own bylaws provided for the establishment and maintenance of an emergency room. Article X, section 1(d)(1)(b) of FMH's Medical Bylaws provides for an emergency room as one of the services of the hospital. Article XI, section 3(e) provides for the creation of an emergency room committee which is required among other things to:

(a) formulate rules and regulations for the continuous coverage of the emergency room; and

(b) supervise the clinical work in that department.

[10] Based upon the above, it cannot seriously be questioned that FMH had a duty to provide emergency room services and that part of that duty was to provide physician care in its emergency room. Having so determined, we must next ascertain whether FMH's duty to provide physician care in the emergency room is non-delegable. That is, we must determine whether, having assumed the duty to staff an emergency room, FMH should be allowed to avoid responsibility for the care rendered therein by claiming that the physicians it provides are not its employees. We conclude that it cannot.

[11] A non-delegable duty is an established exception to the rule that an employer is not liable for the negligence of an independent contractor. W. Keeton, D. Dobbs, R. Keeton, D. Owen, *Prosser and Keeton on The Law of Torts*, § 71 at 511–12 (5th ed. 1984). According to the late Professor Prosser, such a duty "may be imposed by statute, by contract, by franchise or by charter, or by the common law." *Id.* Among the duties considered non-delegable are the following:

> [T]he duty of a carrier to transport its passengers in safety, of a railroad to fence its tracks properly or to maintain safe crossings, and of a municipality to keep its streets in repair; the duty to afford lateral support to adjoining land, to refrain from obstructing or endangering the public highway, to keep premises reasonably safe for business visitors, to provide employees with a safe place to work; the duty of a landlord to maintain common passageways, to make repairs according to covenant, or to use proper

13. The JCAH was formed in the early 1950's by the American College of Surgeons, the American College of Physicians, the American Hospital Association, and the American Medical Association. Its purpose was to establish minimum hospital standards for patient care. For details of the program, see Dornette, *The Legal Impact on Voluntary Standards in Civil Actions Against the Health Care Provider*, N.Y.L.Sch.L.Rev. 925, 925–28 (1977); Holbrook & Dunn, *Medical Malpractice Litigation: The Discoverability and Use of Hospitals' Quality Assurance Committee Records*, 16 Washburn L.J. 54, 57 (1976).

14. Hospitals voluntarily seek accreditation for financial and professional prestige reasons. First, accreditation by the JCAH means the hospital qualifies to participate in the federal Medicare and Medicaid programs. Accreditation by JCAH is deemed substantial compliance with the Medicare conditions of participation. 42 U.S.C. § 1395bb (1982); 42 C.F.R. § 405.1901(d) (1986). *See generally*, Dornette, *supra* n. 13 at 927, Holbrook & Dunn, *supra* n. 13, at 58. Second, JCAH accreditation is often a prerequisite to obtaining approval of internship and residency programs. *See generally, American Medical Association Directory of Accredited Residencies 3* (1975–76), *quoted in* Dornette, *supra* n. 13, at 928. Finally, the institution's reputation and standing in the community is affected by whether it receives JCAH accreditation. *See* Holbrook & Dunn, *supra* n. 13.

care in making them, and no doubt others.

Id. (footnotes omitted). However:

> It is difficult to suggest any criterion by which the non-delegable character of such duties may be determined, other than *the conclusion of the courts that the responsibility is so important to the community that the employer should not be permitted to transfer it to another.*

Id. at 512 (emphasis added). *Accord, Alaska Airlines v. Sweat*, 568 P.2d 916, 925–26 (Alaska 1977).

Our principal decision on non-delegable duty is *Sweat*, 568 P.2d 916. In that case, Sweat sued Alaska Airlines for injuries sustained in an air crash while traveling aboard a Chitina Air Service plane. *Id.* at 922. Chitina had been engaged under a contract with Alaska Airlines to service a portion of Alaska Airlines' regularly scheduled routes. *Id.* at 921, 922. Alaska Airlines contended that Chitina was an independent contractor and therefore it was not liable for Chitina's negligence. *Id.* at 923. The trial court found Alaska Airlines vicariously liable based on Restatement (Second) of Torts § 428. *Id.* On appeal, we affirmed the trial court's decision on the alternative ground that Alaska Airlines owed a common law nondelegable duty of safety to its passengers. *Id.* at 925. We reasoned:

> We believe that the responsibility of a common carrier for the safety of its passengers is so important that the carrier should not be permitted to transfer it to another. A scheduled common carrier such as Alaska is given a monopoly or semi-monopoly primarily for the purpose of furnishing safe and reliable scheduled air transportation. It should not be permitted to barter away its responsibility to the traveling public by means of contracts with other carriers. If this were permissible, an air carrier could avoid liability by engaging in independent contracts for furnishing food, maintenance of its planes and conceivably even for supplying crews. Regardless of whether such contracts may be permitted by regulatory authorities, the traveling public is entitled to look for protection to the certificated carrier responsible for the scheduled route.

Id. at 926.

We have little trouble concluding that patients, such as Jackson, receiving treatment at a hospital emergency room are as deserving of protection as the airline passengers in *Sweat*. Likewise, the importance to the community of a hospital's duty to provide emergency room physicians rivals the importance of the common-carriers' duty for the safety of its passengers. We also find a close parallel between the regulatory scheme of airlines and hospitals. Undoubtedly, the operation of a hospital is one of the most regulated activities in this state. Besides the license,[15] and certificate of need,[16] requirements mentioned above, a hospital must comply with state regulations promulgated to control its activities, AS 18.20.070, 7 AAC 12.610; adopt a state approved risk management program "to minimize the risk of injury to patients," AS 18.20.075; and undergo "annual inspections and investigations" of its facilities, AS 18.20.080. Failure to comply with these statutory requirements can lead to suspension or revocation of the hospital's license. AS 18.20.050.

The hospital regulatory scheme and the purpose underlying it (to "provide for the development, establishment, and enforcement of standards for the care and treatment of hospital patients that promote safe and adequate treatment" AS 18.20.010), along with the statutory definition of a hospital, (an institution devoted primarily to providing diagnosis, treatment or care to individuals, AS 18.20.130(3)), manifests the legislature's recognition that it is the hospital as an institution which bears ultimate responsibility for complying with the mandates of the law. It is the hospital that is required to ensure compliance with the regulations and thus, relevant to the instant case, it is the hospital that bears final ac-

15. *See* AS 18.20.020.

16. *See* AS 18.07.031.

countability for the
for emergency room
hold that a general
duty to provide phy
room care is non-dele
tal such as FMH may
liability by claiming
sible for the result
formed health care w
duty on the hospital
care.

We are persuaded
under which emerge
vided in a modern
rule we adopt today.
consonant with the p
hospital as a multifa
ty responsible for t
care and treatment
tort liability in the m
ner that is consistent
zation of American
simply cannot fatho
depend upon the tec
tus of the emergenc
treats the patient. I
to provide the physi
through any means
means employed, ho
the fact that the h
sible for the care re
has a duty to provi

[12] This holding
We do not change
with which a physici
we extend the duty
gable beyond its nat
ing does not extend
patient is treated by
in an emergency
convenience of the d
are beyond the scop
by an acute care hos
ing is limited to th
patient comes to the

countability for the provision of physicians for emergency room care. We, therefore, hold that a general acute care hospital's duty to provide physicians for emergency room care is non-delegable. Thus, a hospital such as FMH may not shield itself from liability by claiming that it is not responsible for the results of negligently performed health care when the law imposes a duty on the hospital to provide that health care.

We are persuaded that the circumstances under which emergency room care is provided in a modern hospital mandates the rule we adopt today. Not only is this rule consonant with the public perception of the hospital as a multifaceted health care facility responsible for the quality of medical care and treatment rendered, it also treats tort liability in the medical arena in a manner that is consistent with the commercialization of American medicine. Finally, we simply cannot fathom why liability should depend upon the technical employment status of the emergency room physician who treats the patient. It is the hospital's duty to provide the physician, which it may do through any means at its disposal. The means employed, however, will not change the fact that the hospital will be responsible for the care rendered by physicians it has a duty to provide.

[12] This holding is necessarily limited. We do not change the standard of care with which a physician must comply, nor do we extend the duty which we find non-delegable beyond its natural scope. Our holding does not extend to situations where the patient is treated by his or her own doctor in an emergency room provided for the convenience of the doctor. Such situations are beyond the scope of the duty assumed by an acute care hospital. Rather our holding is limited to those situations where a patient comes to the hospital, as an institution, seeking emergency room services and is treated by a physician provided by the hospital. In such situations, the hospital shall be vicariously liable for damages proximately caused by a physician's negligence or malpractice.

[13] In the instant case, Jackson came to FMH as an institution seeking emergency room services. Dr. Power was a physician FMH had a non-delegable duty to provide. FMH is, therefore, vicariously liable as a matter of law for any negligence or malpractice that Dr. Power may have committed. Accordingly, the trial court's ruling on this issue must be reversed. Jackson is entitled to partial summary judgment on the issue of FMH's vicarious liability.

VII

For the reasons outlined above, the trial court's denial of summary judgment on Jackson's theories of enterprise liability and apparent authority are AFFIRMED. However because we hold that FMH has a non-delegable duty to provide non-negligent physician care in its emergency room, the trial court's denial of summary judgment on the theory of non-delegable duty, is REVERSED and REMANDED with instructions to enter partial summary judgment on the issue of FMH vicarious liability in favor of Jackson.

AFFIRMED in part; REVERSED in part; and REMANDED.

MOORE, J., not participating.

HOUSE BILL 166

EXPLANATION OF SECTION 17 SUBMITTED BY HEALTH ASSOCIATION OF ALASKA

I. Sections 17(a), 17(b), 17(d) and 17(e)(1).

These sections repeal the holding of Jackson v. Power, 743 P.2d 1376 (Alaska Supreme Court, October 21, 1987), that a general acute care hospital is vicariously liable for the negligence of independent contractor emergency room physicians (and, by inference, all other members of an independent medical staff).

These sections are identical to SB 461, sections (a)-(d), introduced by Senators Jones, Fischer, Coghill, Faiks and Kelly during the last session. With minor changes, the substance of SB 461 was incorporated in Section 11 of CSHB 85, which passed the Senate. Attached are summary materials submitted by the Health Association of Alaska in support of SB 461.

II. Section 17(c).

This section is new and creates a "safe harbor" provision enabling hospitals that comply with the public notice requirements set forth in the section to avoid liability on a theory of ostensible, apparent or implied agency.

This section deals with two problems. First, some opponents of SB 461 felt that hospitals should be vicariously liable for the negligence of independent

contractor health care providers because the public reasonably looks to the hospital (not the individual physicians) as the health care provider, and the hospitals do nothing to dispel this belief. This was characterized by some opponents as a "truth in advertising issue."

Secondly, although hospitals may be held liable for the acts of independent contractor health care providers on an implied agency theory only upon a showing that the hospital "held itself out" as the employer of the provider, there were no guidelines to assist hospitals in determining what steps they might take to avoid this charactization. Since the issue of implied agency is one of fact, plaintiffs routinely name hospitals as "deep pocket" defendants in the hope that they can convince a jury that the plaintiff had no way of knowing that the negligent provider was in fact an independent contractor.

Section 17(c) solves both problems by permitting hospitals that wish to avoid vicarious liability on a "holding out" theory to give the form of public notice required by the subsection. The public receives fair notice that it must look to the provider, not the hospital, in the event of injury. The hospital knows exactly what it must do to avoid liability on this theory.

HEALTH ASSOCIATION OF ALASKA
February 1988

LEGISLATIVE SUMMARY -- SB 461, LIABILITY OF HOSPITALS FOR NON-EMPLOYED PHYSICIANS AND OTHER HEALTH PERSONNEL

By: Senators Jones, Coghill, Faiks and Kelly

On October 16, 1987, the Alaska Supreme Court ruled in Jackson v. Power (no. 3237) that a general acute care hospital has a nondelegable duty to provide emergency room services, and therefore, the hospital is vicariously liable for the negligence of an emergency room physician.

** The Jackson decision imposes liability on hospitals for the negligence of non-employee emergency room physicians solely because the hospital is required by law to provide emergency room services and is regulated in the provision of those services, without requiring the plaintiff to show that the hospital has been negligent or that it has violated any specific regulatory requirement.

** The implications of the Jackson decision extend far beyond the emergency room. Although the Jackson case dealt only with the relationship between the hospital and non-employee emergency room physicians, the rationale of the case logically extends to other non-employee physicians and health care providers. Under the common law prior to the Jackson decision a hospital was not vicariously liable for the negligence of the non-employees if the hospital itself was not negligent and had complied with all applicable statutory and regulatory requirements.

** The Jackson decision runs counter to modern trends of apportioning liability according to fault. Recent tort reforms were designed to provide some relief to public entities, which were often named as "deep pocket" defendants, even though their share of the responsibility for the injury was negligible. The Jackson case insures that municipally owned and non-profit hospitals will be named as deep pocket defendants in every case involving physicians negligence, even though the hospital was not negligent and has done everything within its power to comply with statutory and regulatory requirements. In one recent case, for example, the plaintiff dismissed all of the allegedly negligent physician defendants and went to trial solely against the corporate hospital.

** The ruling will not improve hospital and emergency room care because, by definition, the Jackson rule applies where there is no fault on the part of the hospital. Hospitals have always been liable for their own negligence, and would continue to be so liable if Jackson were legislatively repealed.

** The Jackson ruling could decrease hospital and emergency room response time if hospitals react to the ruling by requiring emergency room physicians to practice more "legal" or "defensive medicine" -- more tests, more consultations, etc. Emergency

(over)

situations are inherently risky. The legislature, for example, has granted immunity to EMTs, paramedics and ordinary citizens acting in emergency situations. These legislative choices reflect a policy decision that the need for swift action in emergency situations outweighs the policy of compensating injured plaintiffs. The Jackson decision undercuts this legislative policy.

** Hospital and Emergency room operating costs could be increased also if hospitals react to Jackson by imposing more "defensive medicine" requirements.

** Unless hospitals dramatically restructure their relationship to physicians (by requiring them to become hospital employees, for example) the net result of the Jackson decision probably will be to increase insurance costs as both hospital and doctor insure to cover the same risk.

** There is no showing that medical malpractice plaintiffs have experienced difficulty collecting their judgments. Most physicians carry adequate malpractice insurance. The addition of a "deep pocket" corporate hospital to the cast of defendants, however, will probably increase the size of jury verdicts.

** The burden of the Jackson decision will fall on municipally owned and non-profit hospitals, which are already caught in a cost squeeze from state and federal regulatory and rate requirements.

** SB 461 corrects the Supreme Court ruling by clarifying that hospitals are not liabl for acts or omissions of non-employed physicians or other healt.. professionals, solely for the reason that they must provide those services under Alaska Statue or regulations. It returns the law to where it was prior to the decision, with the hospital liable for its negligence or intentional misconduct.

** The Medicaid Rate Commission reports that hospital malpractice insurance premiums increased from a total of $3,147,262.00 in 1986 to $5,377,918.00 for 1988. An increase of over $2 million dollars.

The passage of SB 461 will prevent an even a greater escalation of hospital liability insurance costs.

For More Information Contact:

Harlan Knudson, Executive Director
Health Association of Alaska - 586-1790

David Crosby, Attorney
Health Association of Alaska - 586-1786

Jerry Reinwand, Lobbyist
Health Association of Alaska - 586-8966

# # #

Claim File Data Analysis: Overview

ISO DATA, Inc.

December 1988

ISO DATA, INC.

(illegible)

December 1988

To: Readers of the Claim File Data Analysis

During the past several years, a national debate has focused on the perceived advantages and disadvantages of tort reform. As a matter of course, insurers make available to regulators and the public vast amounts of financial and statistical information. Nonetheless, insurers, regulators, public policymakers, and others have expressed a need to obtain relevant information from claim files to assist in evaluating the complex issues associated with changes to tort law.

In 1986, ISO announced its sponsorship of two high priority claim studies. The first study, the Claim Evaluation Project, was conducted by the independent policy and management consulting firm of Hamilton, Rabinovitz & Alschuler, Inc., under ISO's sponsorship. It was completed in May 1987.

The second study, the Claim File Data Analysis, is now completed. It analyzes detailed information gathered from over 13,000 actual commercial liability claim files, submitted by 24 participating insurer groups. The study was conducted by ISO DATA, Inc., a subsidiary of Insurance Services Office, Inc.

The report contains extensive information that will help interested parties better understand the issues surrounding the ongoing public policy debate.

Among the key findings of this second study are the following:

- On average, a claimant's liability insurance compensation represented several times his or her compensable economic loss.
- Insurer total claim costs are driven by a small minority of larger claims that involve more serious injury, are reported later, and characteristically require years to resolve after extended litigation.
- Current application of tort law doctrines (such as joint and several liability and the collateral source rule) contribute significantly to higher insurer claim costs.
- Plaintiffs and courts frequently treat governmental entities as "deep pockets." Governments are more likely than other insureds to make settlement payments exceeding their percentage of fault.

The types of risks any one insurer covers may vary from the average. Therefore, the aggregated results of the sample claims may not reflect any individual insurer's claim portfolio in whole or in part. Thus, although the study is based upon the best and most comprehensive information that could be collected and evaluated, the study was not designed for, nor does it result in, a pricing of tort reform.

Nevertheless, the two ISO claim studies clearly suggest that meaningful tort reform may reduce the number and dollar value of insurance losses. The size of this reduction will vary depending on the package of reforms enacted in a state and an individual insurer's book of business.

However, tort reform is only one of many events and forces that affect insurance prices. Such factors as court decisions and the responses to those decisions by claimants, lawyers, juries, and the judiciary, as well as inflation in health care costs and wage levels, interact continually to influence insurers' loss costs. Despite the enactment of tort reform by many jurisdictions in 1986 and 1987, underlying insurer claims costs have continued to rise.

The property and casualty insurance industry is highly dynamic and intensely competitive in pricing, in product, and in marketing strategies. An operational reality of the business is that anything likely to increase profitability for insurers is very soon converted by competitive pressures into reduced premium levels designed to increase or retain market share. The actual impact of tort reforms will be reflected in insurers' loss experience over time. Until then, informed judgment, supplemented by the information in this and other studies, will assist insurers in continuing to make the difficult pricing judgments necessary to estimate cost savings attributable to tort reform.

Fred R. Marcon
Chairman

Contents

Sections

Page

I. Background

A. Introduction

The recent problems in the liability insurance marketplace produced hardship and dislocation for some businesses, local governments, and professionals. These entities need affordable liability insurance to protect their operations. Not surprisingly, a highly charged public debate arose over the root causes of the problems, with some observers focusing on the effects of rising costs and unpredictability within the tort system—and others arguing that primary responsibility for the problems lay with the behavior of the property and casualty insurance industry itself.

A major by-product of that debate has been a surge in efforts to obtain more data about insurer claim costs. In 1986 alone, 17 states enacted a wide range of data reporting bills, with a diversity of requirements that has virtually precluded a uniform response.

Expanded interest in insurer claim cost information appears to reflect a multiplicity of forces. In some cases, the data requests indicate a desire to improve understanding of the sources of claims and the dynamics of the claim negotiation process. Other requests reflect an understandable impulse to evaluate the cost effects of traditional tort law doctrines and recently enacted and potential new tort reforms. Sometimes, the specific objectives behind the data requests are less clear. In general, the new data reporting laws seem to be based on the assumption that more information will, in some undefined way, inevitably lead to better-informed public policy.

Supporters of these laws appear to presume that the social value of more information exceeds the cost of producing that information—or that those costs are irrelevant.

Before enactment of the recent legislation, property and casualty insurers were already subject to extensive data reporting requirements. (See ISO Insurance Issues Series, *Insurance Data: A Close Look*.) The recent legislation has imposed a massive new burden on insurer data reporting and claim functions. Nonetheless, from time to time, insurers have supplemented traditional financial and statistical data with information from other sources. Where specific claim information appeared useful in enhancing public debate, insurers have undertaken claim studies, such as in the areas of medical malpractice and product liability.

To address in an effective manner the perceived needs for more data, Insurance Services Office, Inc. (ISO), sponsored two claim data studies.

The first study, the *Claim Evaluation Project*, was conducted by the independent public policy and management consulting firm of Hamilton, Rabinowitz & Alschuler, Inc., under ISO's sponsorship. It was completed in May 1987. The study involved the evaluation by experienced claims personnel of six typical, but hypothetical, claim situations. The *Claim Evaluation Project* provided an early look at the direction and relative size of the effects of various tort reforms on bodily injury indemnity costs. The study identified the likely effects of major tort reforms in the claim situations tested. In the opinion of the experts who participated in the *Claim Evaluation Project*, the qualifications and exceptions incorporated into many of the tort reform statutes largely eliminated the effects of those tort reforms in reducing claim costs. The study also concluded that enactment of a three-point program[1] of relatively straightforward tort reforms would produce significant cost reductions in virtually all of the claim situations tested.

This Overview presents key findings from the second study, the *Claim File Data Analysis* (hereafter, "the study").

B. Study Objectives and Limitations

The *Claim File Data Analysis* is a longer-term analysis by ISO DATA, Inc., of 13,316 actual commercial liability claim files submitted by 24 insurer groups. In the aggregate, the participating insurers write a significant portion of the general liability coverage written in the United States. A Technical Analysis of the study is also available from ISO DATA, Inc., for those seeking a more complete understanding of the issues highlighted in this Overview. The Technical Analysis presents an in-depth review of the findings and includes presentations of 14 major groups of reports.

Because the requests for more insurer claim data have been motivated by a variety of concerns, this study sought to meet a wide range of objectives. The study represents the broadest survey of commercial liability claim files ever undertaken, and thus the most detailed picture ever produced of the commercial liability compensation process. The study includes the first claim file analysis of claims against governmental and municipal insureds. It also contains a broad-based analysis of the effects on insurer claim costs of several important tort law doctrines, including joint and several liability, the collateral source rule, and punitive damages.

The *Claim File Data Analysis* addresses a series of important issues—compensation levels relative to claimant losses, the size distribution of claims, the effects of litiga-

[1] ***The three-point program consisted of the abolition of the rule of joint and several liability, relaxation of the collateral source rule (including set off of collateral benefits), and establishment of a ceiling of $250,000 on awards of non-economic damages.***

tion on the length of time a claim is open, and others. These topics are critical for understanding the workings of the insurance mechanism and evaluating tort law policy. The commercial liability claims universe is not monolithic—large and small claims, for example, exhibit sharply different characteristics—and the study delineates such distinctions.

The objective of this study is not to present the case for or against any particular policy initiative. Rather, the goal is to assist interested parties in making difficult judgments about tort law policy issues. ISO DATA, Inc., hopes the study will encourage a more informed public policy debate and avoid the need for further, less useful, but expensive state and federal government demands for data.

Any claim file study must be reviewed in light of the limitations of such studies. A complete discussion of the availability, uses, and limitations of claim file information can be found in *The Report of the Statistical Information Advisory Committee to the NAIC Legal Liability Insurance (D) Task Force*, dated December 1986. These limitations include the following:

- Information needed to study public policy issues may not be available in the claim file, or may be available only when a claim actually goes to verdict.
- Claim studies contain information only from primary insurers in the admitted market.[1]
- Claim file information does not measure trends or changing conditions or the effects of future change. A claim study is a "snapshot" at one point in time.

These limitations, inherent to all claim studies, put certain constraints on the uses of the *Claim File Data Analysis*.

First, the study is about claim costs, not prices. The study provides no information on premium collected or on exposures insured. Both elements are necessary to measure the appropriateness of premiums. More important, during periods when tort laws are in great flux, a claim file study can never yield precise quantitative judgments about current prices.

Current insurance prices reflect judgments about future claim costs—specifically, the costs of paying the claims expected in the years ahead under a policy written today. But commercial liability losses "mature" slowly. That is, the higher-valued claims producing the preponderance of insurer claim costs tend to be litigated and settled years after they are first reported. Therefore, claims that have actually closed are predominantly those reported years in the past. To the extent that the tort system is in ferment, this study could not capture information on the recent changes that will determine future claim costs.

Second, even at a single point in time, a study like the *Claim File Data Analysis* cannot produce a precise, definitive finding on the effects of particular tort law reforms. Insurer claim costs are, by definition, the best measure of the effects of tort law trends on insurer costs. And over time, the aggregate effects of tort law changes—increased valuations of injury or expansion of liability that raise costs or meaningful tort reforms that reduce costs—are reflected in insurer claim cost data regularly submitted to regulators.

In settling claims, however, insurers do not typically calculate how claim payments would have differed if some tort law element had been different. Insurers, claimants, and attorneys negotiate settlements on the basis of existing law within a jurisdiction; they do not make a record of what the settlement would have been had the law been different, nor do they specify how particular doctrines of existing law contributed to their final settlement figure. The best a claim file study can do in measuring the impact of specific tort law changes is to ask claims professionals to offer a subjective estimate of how the outcome of a multifaceted negotiation might change if one or more elements of the law were different.

C. Scope of the Study

The usual insurance claims survey is a study of closed claims, in which all outstanding contractual obligations of the insurance company have been satisfied. Analysts value closed claim studies because all payment information is fully developed, and closed claims present a composite picture of claims that have been resolved. But cases settle slowly—it may take a decade or more to resolve a disputed commercial claim—and the data collected in many case files may be stale by the time the claims for a given period of time have all closed. This problem is compounded by the effects of a dynamic environment, in which law, social attitudes, scientific knowledge, and, as a result, claim frequency and severity change rapidly. To minimize this problem, the *Claim File Data Analysis* looked at three separate samples of claims, as described below.

[1] *Claim File Data Analysis did collect information from the surplus lines subsidiaries of the participating insurer groups, but they are a minority of the non-admitted market.*

Professional claims personnel from a sample of insurers representing at least 50% of the premium volume in each of the 27 states filled out a detailed questionnaire for each eligible claim. A complete description of the specifications and scope of the study can be found in the Technical Analysis of the *Claim File Data Analysis*. See Section IV of this Overview for lists of the participating insurers, states surveyed, and lines of business included.

Study Part 1—Policy Year 1983 Claims of $25,000 or More

To allay the concern about old claims in a dynamic environment, Study Part 1 surveyed claims—both open and closed—that arose out of policies written during 1983. This is a relatively recent policy year, considering that a long settlement process is common for large commercial liability claims. The study collected information on all eligible commercial liability claims (other than medical malpractice) with a bodily injury indemnity of $25,000 or more. The evaluation date for these claims was December 31, 1986. Claims closed before July 1, 1985, were excluded, because the claim files were too old or too difficult to locate. Claims reported after January 1, 1986, that were still open were also excluded, because they were too immature to produce meaningful information. Thus, this sample does not represent all claims from policies written during 1983.

These requirements permitted the collection of information on recent large claims, yet assured that the claims were mature enough to permit meaningful analysis.

Study Part 2—August 1987 Closed Claim Sample

Small claims in general close quickly, and the information required for this study might not be routinely maintained in claim files. Therefore, a retrospective study of small claim files may not provide as much meaningful information as a study conducted as the claims close—while the information is still fresh in the minds of the claims handlers.

Thus, Study Part 2 examined all commercial liability bodily injury claims (other than medical malpractice) that closed during the first week of August 1987, regardless of size, date of accident, or when the underlying policy was written. The survey forms were completed as the claims closed or soon thereafter.

Study Part 3—Policy Year 1983 Governmental Claims under $25,000

A key policy concern has been the availability of liability insurance to governmental entities at an affordable cost. Therefore, Study Part 3 collected information on identifiable bodily injury claims under $25,000 against governmental entities that arose from policies written during 1983. (Governmental claims of $25,000 or more were reported in Study Part 1, with the non governmental claims.) Both open and closed claims were surveyed with the same exceptions as noted above for Study Part 1.

D. NAIC Review

Once the initial study design was prepared, ISO DATA, Inc., invited the National Association of Insurance Commissioners (NAIC) to review the technical specifications and methodology of the *Claim File Data Analysis*. On January 5, 1987, the NAIC sponsored a meeting in Washington, DC, at which 13 organizations reviewed the study specifications. As a consequence of that review, ISO DATA, Inc., made various modifications in the survey form. The NAIC confirmed that the study specifications met its concerns and those of the organizations that participated in its review. In addition, to assure that the study would gain broad acceptance, the Illinois Department of Insurance engaged the independent public accounting firm of Ernst & Whinney to review the study.

The objective and scope of Ernst & Whinney's review, as defined by the Illinois Department of Insurance and the NAIC, was to determine whether the data collection process had been performed in a manner sufficient to provide a reasonable degree of assurance that the compiled data was free of material errors or irregularities. To accomplish this objective, Ernst & Whinney:

- reviewed a random sample of survey forms and compared the data to the participating insurer's claim files
- performed a general computer controls review as related to the inputting, editing, processing, and output of the study data
- recomputed the study's output processing for a sample of output reports

Based on the procedures performed, Ernst & Whinney reported to the Illinois Department of Insurance and the NAIC that nothing came to their attention that caused them to believe that the compiled data was not collected in a reasonable manner within the *Claim File Data Analysis* specifications.

II. Major Findings

A. Adequacy of Compensation

For the vast majority of claimants in the study, liability insurance compensation covered at least their fault-adjusted economic loss (such as medical costs, past and future wage losses, and rehabilitation costs). On average, claimants received several times their compensable economic losses.

These findings suggest that many claimants received substantial compensation for non-economic damages, including such intangible injuries as pain and suffering, mental distress, and loss of consortium.

Since non-economic damages are intangible, a quantitative analysis cannot say whether compensation for non-economic damages is adequate or inadequate. Therefore, the *Claim File Data Analysis* focuses on whether claimants received compensation greater or less than their economic losses. Specific findings include the following:

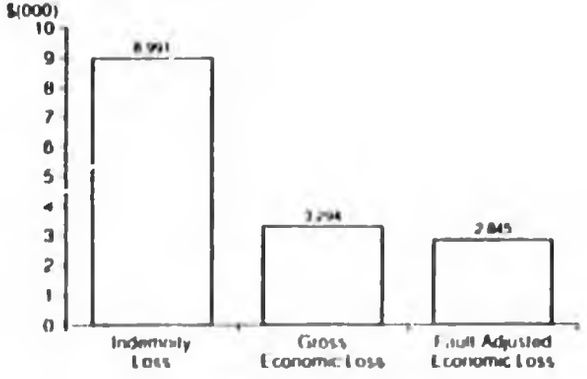
- Over 90 percent of claimants were compensated for at least their fault-adjusted economic loss. (Fault-adjusted economic loss is the claimant's economic loss reduced by the estimated percentage of fault attributable to the claimant.) On average, in Study Part 2 (closed claim sample), claimants received more than 3 times their fault-adjusted economic loss. Even when not fault-adjusted, claimants received an average of 2½ times their economic loss.

- Claimants with small claims received, on average, several times their fault-adjusted economic loss. The tendency toward compensation exceeding economic loss declined as the level of economic loss increased.

Figure 1

Average Compensation Compared to Economic Loss

Study Part 2 - Closed Claim Sample (With Payment Only)



- The great majority of claimants had relatively small medical, wage, and "other" economic losses. Medical expenses predominated at the lower levels of economic loss, and lost wages predominated at the higher levels.

The real compensation received by many plaintiffs may be overstated because plaintiffs' legal fees were not reflected. Although many small claims did not involve an attorney, almost all large claims did.

On the other hand, the findings understate the total recovery received by many claimants. Claimants often received payments from collateral sources (such as health insurance, Workers' Compensation, and no-fault insurance) as well as reimbursements from other liability policies (such as excess and umbrella policies) and direct payments from the liable parties (because of self-retentions, settlements exceeding policy limits, and payments from non-insured [illegible]). However:

- Considering known collateral source payments (with no lien attached) as well as liability compensation, claimants, on average, received a total recovery several times their level of fault-adjusted economic loss. In Study Part 1 (claims of $25,000 or more) claimants received a total average recovery of 2½ to 3 times their fault-adjusted economic loss. In Study Part 2 (closed claim sample), reflecting all claim sizes, the average multiplier was about 4 times the fault-adjusted economic loss.

An example will clarify these findings. Assume that a claimant suffered a $10,000 economic loss ($5,000 in medical costs and $5,000 in lost wages) and that the claimant was 25 percent responsible for his or her own injury. The claimant's fault-adjusted loss was 75 percent of $10,000, or $7,500. Assume that the claimant received $20,000 in liability compensation and $10,000 from collateral sources, for a total recovery of $30,000. The multiple of total recovery (excluding legal fees) to fault-adjusted economic loss was $30,000 divided by $7,500, or 4 to 1.

B. Claim Size Distribution

The claims in the study can be divided into two groups—large claims and small claims. The study found that these groups exhibited very different characteristics.

The vast majority of claims were relatively small. In Study Part 2 (which had a size-of-loss distribution similar to the overall commercial liability bodily injury claims universe), more than 90 percent of the claims were settled for less than $25,000.

Figure 2

Size of Loss Distribution by Percentage Of Claims and Percentage of Losses

Study Part 2 - Closed Claim Sample

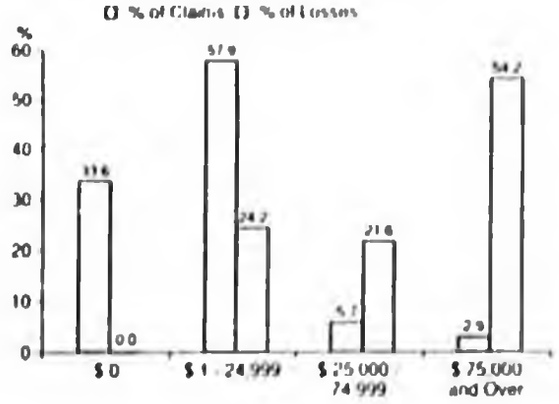


Table 1

Average Losses by Study Part

	Number of Claims	Average Loss per Claim*	Average Loss per Incident*
Study Part 1 – Policy Year 1983 –			
Claims of $25,000 or More	6,707	$91,026	$128,114
Study Part 2 – Closed Claim Sample			
No Payment	1,965	0	0
Payment under $25,000	3,390	4,495	4,646
Payment of $25,000 or More	499	95,394	109,817
Study Part 3 – Policy Year 1983 –			
Governmental Claims under $25,000	755	6,903	13,748

** Throughout this study, a claim refers to a demand for compensation from a particular insured. Thus, if two parties who were injured in a single event each seek compensation from each of three insureds, there are six claims. An incident refers to the number of injured parties seeking compensation, regardless of the number of insureds. Thus in the prior case there are two incidents.*

A relatively small number of large claims accounted for the vast preponderance of total liability insurance compensation dollars. In Study Part 2, claims of $25,000 or more accounted for only 9 percent of the claims but 76 percent of all compensation paid. Fewer than 3 percent of the largest claims were responsible for 54 percent of the total compensation paid. In Study Part 1 (claims of $25,000 or more), the same pattern held. Claims of $150,000 or more accounted for only 16 percent of all Study Part 1 claims but represented 51 percent of total Study Part 1 compensation.

Table 1 displays the size distributions of claims and average loss levels.

The fact that a small number of large claims drive total insurer claim costs has several implications:

- The frequency of litigation involving small claims is less critical in determining total insurer claim costs than the frequency of litigation and award levels in the larger cases.
- Tort reforms that target the high-cost cases can play a critical role in determining total insurer claim costs.
- To the extent that liability doctrines continue to change while the larger claims remain subject to years of litigation before settlement, insurers will confront a systemic problem of unpredictability in gauging future claim costs.

Just as the claims in this study do not fully reflect total compensation received by claimants, neither do they provide a full picture of insurer costs. The study was limited to bodily injury claims and excluded claims for property damage. While the study did examine allocated loss adjustment expenses (insurer legal expenses and other expenses that can be allocated to a specific claim), these costs are not included in Table 1. Also the study did not include some types of claims referred to in the Institute of Civil Justice report, *Trends in Tort Litigation: The Story Behind the Statistics*, such as some high-stakes personal injury suits (for example, medical malpractice) and mass tort class action suits. Had such high-cost claims been included, the phenomenon of large claims playing a prominent role in driving total insurer costs would have been even more evident.

C. Settlement Patterns and the Role of Litigation

An analysis of claim settlement patterns and the frequency of litigation extends and reinforces the striking picture of two very different worlds within the commercial liability claims universe.

Most claims involved relatively modest sums of money, minor injuries, and a single insured. By and large, smaller claims were reported shortly after the accident, did not produce litigation, and were settled quickly.

By contrast, a small minority of larger claims accounted for the overwhelming preponderance of total liability insurance compensation dollars. These claims generally involved more serious injuries and often had multiple defendants. They tended to be reported more slowly, usually led to litigation, and were resolved slowly. Indeed, even among litigated claims, those involving the largest sums of money were resolved the slowest.

The study's findings on settlement patterns and litigation include the following:

- Within a year of the accident, more than 90 percent of all claims were reported, but claims reported later involved higher levels of compensation.

- In Study Part 2 (closed claim sample), 56 percent of the claims were closed within a year of the first report, but those claims accounted for only 14 percent of the total liability compensation insurers ultimately paid. Three years after the first report, only 12 percent of all claims remained open, but they represented 40 percent of the liability compensation that insurers ultimately paid. Looked at another way, average compensation for claims closed within 6 months of the first report was about $2,000. By contrast, average compensation for claims closed 3 to 4 years after the first report w[illegible],000.

Figure 3

Average Compensation by Time from Accident to First Report

Study Part 2 - Closed Claim Sample (With Payment Only)

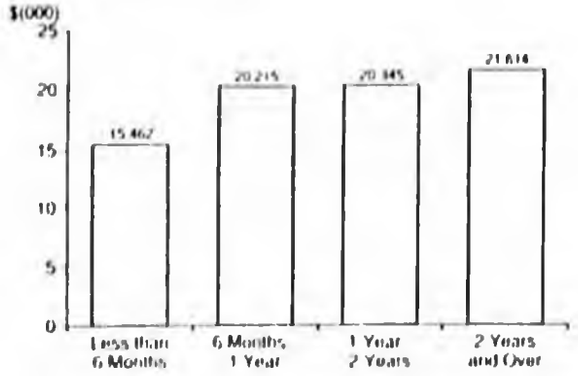
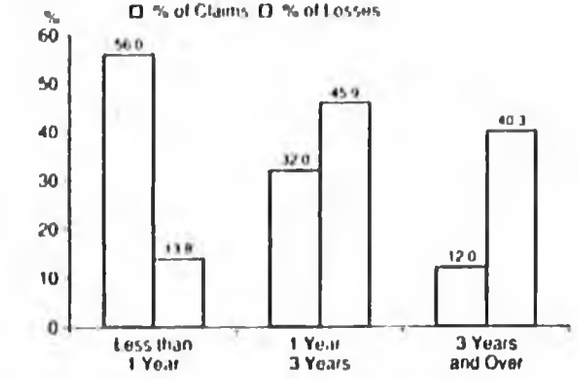


Figure 4

Percentage of Claims and Losses by Time From First Report to Case Closed

Study Part 2 - Closed Claim Sample (With Payment Only)



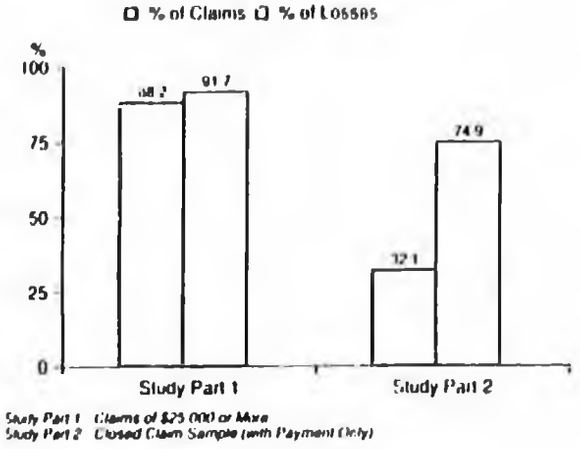
- Within Study Part 1 (claims of $25,000 or more), 88 percent of all claimants filed lawsuits. But in Study Part 2 (closed claim sample), where 90 percent of the claims were under $25,000, only 32 percent filed lawsuits. Those claims accounted for 75 percent of the total liability compensation ultimately paid. Similarly, while 98 percent of all Study Part 1 claimants were represented by an attorney, only 64 percent of Study Part 2 claimants had an attorney.

- In commercial automobile accident cases, claims involving a lawsuit remained open twice as long after the accident date as claims without a lawsuit. In "all other liability" cases, claims with a lawsuit remained open almost three times as long. Moreover, longer periods of litigation corresponded to higher claim costs ultimately being paid. The average compensation rose from $12,000 for claims closed within 6 months after the suit was filed to $77,000 for claims closed from 48 to 60 months after the suit was filed. Claims involving multiple defendants and greater severity of injury understandably took longer to settle than simpler cases. The consequences for insurers were higher legal costs and delay in determining claim costs.

- Fewer than 2 percent of the claims went all the way to verdict.

Figure 5

Percentage of Claims and Losses With Lawsuit Filed



Study Part 1 Claims of $25,000 or More
Study Part 2 Closed Claim Sample (with Payment Only)

Figure 6

Average Time from Accident Date to Case Closed

Study Part 2 - Closed Claim Sample (With Payment Only)

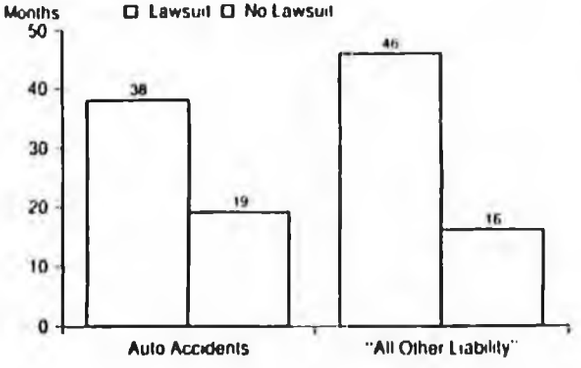
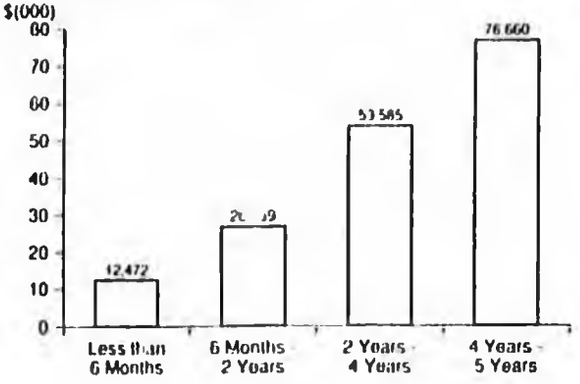


Figure 7

Average Compensation by Time from Suit Filed to Case Closed

Study Part 2 - Closed Claim Sample (With Payment Only)



These findings have significant implications for insurers and for the tort law policy debate. Some observers have discounted the effects of recent tort law trends on the insurance mechanism by making two assertions. First, some have said that, while tort awards for serious injuries may be rapidly rising, median tort awards for typical, small tort actions have remained relatively constant. Second, some have noted that, as a practical matter, most claims are settled through negotiations rather than through litigation.

In fact, the study suggests that tort trends producing increased dollar valuations of serious injury cases will have a very real effect on the insurance mechanism. The litigated claims constitute the majority of insurer claim costs and thus drive the insurer claim cost base. The vast preponderance of those litigated claims are indeed settled before verdict, but the parties reach their settlements in the context of lawsuits. The litigants' expectations of how those claims would be resolved if the suits went to verdict have a strong influence on the amounts of the settlements. In short, the study indicates that insurer claim costs will be largely determined by tort law trends affecting the crucial minority of cases involving serious injuries and large awards or settlements.

Because the claims driving insurer claim costs typically take many years to close, an analysis of recent policy years cannot quantify external factors that may change total claim costs. The lengthy claim settlement process described by this study constitutes a severe obstacle to efforts to quantify the costs of tort reforms in advance or to predict future claim cost levels with precision.

D. Implications of Tort Doctrines

The study provides evidence that current applications of some tort law doctrines contribute to higher claim costs. This section examines three tort law issues and related findings of the *Claim File Data Analysis*.

1. Joint and Several Liability

Under the traditional rule of joint and several liability, a plaintiff injured by more than one defendant may seek and receive full payment of any court award from any liable defendant, regardless of the share of the fault assigned by the court to that defendant. Critics assert that it is unfair to force a defendant who played a minor role in causing an injury to pay all or most of a large judgment. As an alternative, these observers have suggested —and several states have adopted—a rule of several liability only. Under such a rule, each defendant is liable only for the percentage of the total award corresponding to that defendant's percentage of fault.

The study does not assess the merits of any side in the policy debate over joint and several liability. Rather, the study provides a firmer factual basis for that debate. Specifically, the study addresses the issue of how often defendants pay a percentage of the total settlement larger than their indicated percentage of fault. The study also identifies some of the key characteristics of multi-defendant claims, including their cost implications.

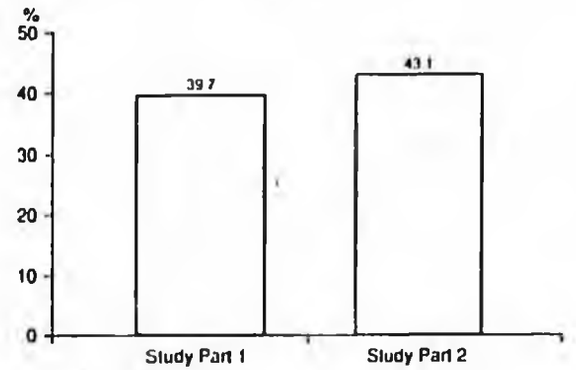
In addition, the study addresses the extent to which claimants are responsible for their own injuries, an issue arising in the context of both single- and multi-defendant claims.

The study's findings on joint and several liability and claimant fault include the following:

- Insureds in multi-defendant situations frequently paid a larger percentage of the settlement than their percentage of fault. The insured's estimated percentage of the settlement was larger than the insured's estimated percentage of fault in about 40 percent of the multi-defendant cases.

Figure 8

Percentage of Multi-defendant Cases In Which Insured's Percentage of Settlement Exceeded Percentage of Fault

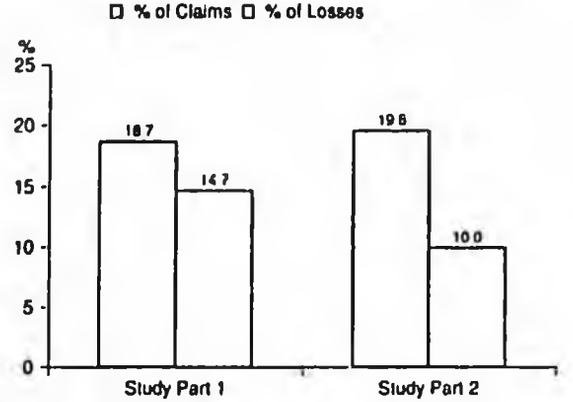


Study Part 1 - Claims of $25,000 or More
Study Part 2 - Closed Claim Sample (with Payment Only)

- In both Study Part 1 (claims of $25,000 or more) and Study Part 2 (closed claim sample), the claimant was estimated to be 50 percent or more responsible for his or her own injury in almost 20 percent of the claims. In Study Part 1, 15 percent of the total liability insurance costs went to claimants who were estimated to be 50 percent or more responsible for their own injuries. The average compensation for those claims was more than $70,000.

Figure 9

Percentage of Claims and Losses With Claimant 50% or More Responsible



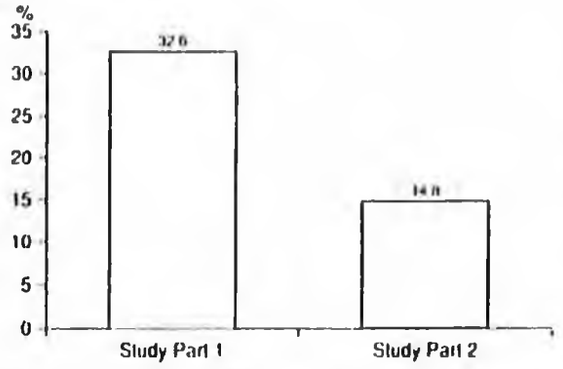
Study Part 1 - Claims of $25,000 or More
Study Part 2 - Closed Claim Sample (with Payment Only)

- Average compensation in multi-defendant cases significantly exceeded compensation in single-defendant cases. About one third of the larger claims (Study Part 1) were multi-defendant cases, whereas only about 15 percent of the Study Part 2 claims, mostly small claims, were multi-defendant cases. In Study Part 1, insurers paid an average of 2.4 times more in multi-defendant cases than in single-defendant cases. In Study Part 2, insurers paid an average of 3.7 times more in multi-defendant cases than in single-defendant cases.

- Multi-defendant cases also generated disproportionately higher legal costs than single-defendant cases. When allocated loss adjustment expenses (insurers, legal costs, and other claim expenses) were calculated as a percentage of compensation paid to claimants, those expenses were more than 75 percent greater in multi-defendant cases than in single-defendant cases.

Figure 10

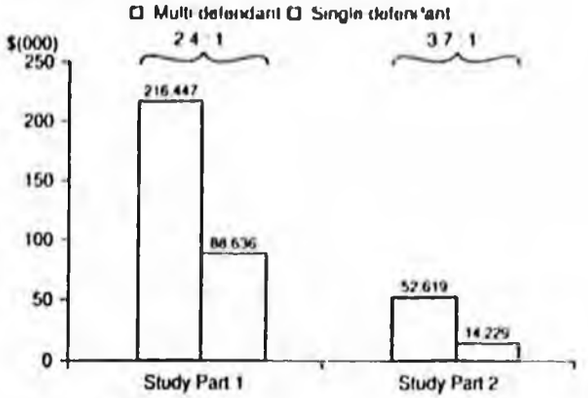
Multi-defendant Cases As Percentage of All Cases



Study Part 1 Claims of $25,000 or More
Study Part 2 Closed Claim Sample (with Payment Only)

Figure 11

Ratio of Average Losses in Multi-defendant Cases to Average Losses in Single-defendant Cases



Study Part 1 Claims of $25,000 or
Study Part 2 Closed Claim Sample (with Payment Only)

2. Collateral Sources

Under the collateral source rules in effect in most jurisdictions, the fact that a claimant has received—or is entitled to receive—benefits from a collateral source (such as no-fault or private health or disability insurance) does not reduce any settlement or court award. Indeed, in many jurisdictions, the availability of collateral source payments may not even be introduced as evidence at trial. Critics say that it is unfair for some claimants to recover twice for the same injuries. In some jurisdictions alternatives to these rules have been proposed or enacted. These alternatives either permit collateral source benefits to be introduced as evidence or more directly mandate that the amount of the settlement or court award be reduced by the amount of collateral benefits already received by the claimant.

The *Claim File Data Analysis* sheds light on a number of issues related to collateral sources.

- Many claimants did, in fact, receive recoveries from collateral sources as well as from liability insurance. In Study Part 1 (claims of $25,000 or more), 57 percent of the claimants were reported to have medical collateral sources available and 36 percent of the claimants were reported to have disability collateral sources available. In Study Part 2 (closed claim sample), claimants were reported to have medical collateral sources available in 36 percent of the cases and disability collateral sources in 16 percent of the cases.

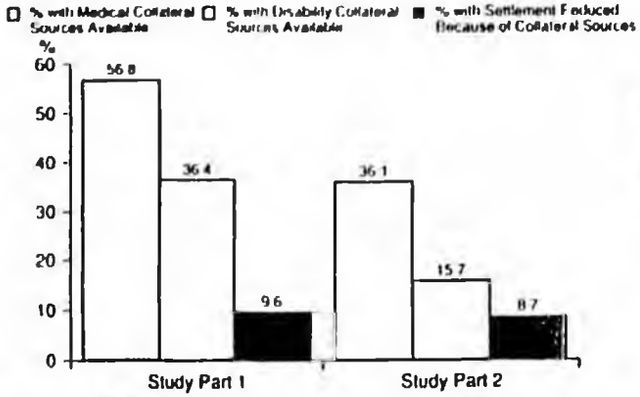
- The study also indicated the potential for cost reductions that the relaxation of the traditional collateral source rule would permit. Despite the wide availability of collateral source benefits, only 9 percent of all claims in both study parts had settlements or court verdicts reduced because of the availability of collateral sources.

- In cases where collateral sources did reduce the settlement or court awards, the dollar effect was significant. In Study Part 1 (claims of $25,000 or more), in claims that were reduced because of collateral sources, the average reduction was 20 percent. In Study Part 2 (closed claim sample), the average reduction was 28 percent for affected claims.

- For Study Part 1, Workers' Compensation was the most prevalent collateral source of benefits reported. Almost 40 percent of Study Part 1 claimants who had a collateral source reported and almost 20 percent of Study Part 2 claimants who had a collateral source reported had Workers' Compensation benefits. This is consistent with the proportion of claimants whose injuries were related to their employment. Among the employed claimants in Study Part 1, 41 percent of the injuries were work-related, and among the employed claimants in Study Part 2, 16 percent of the injuries were work-related.

Figure 12

Percentage of Claims with Collateral Sources Available and Percentage with Settlement Reduced Because of Collateral Sources



Study Part 1 - Claims of $25,000 or More
Study Part 2 - Closed Claim Sample (with Payment Only)

Figure

Distribu[illegible]laims by Type of Collateral Source

Study Part 1 - Claims of $25,000 or More

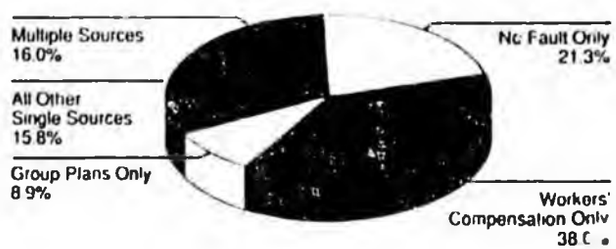
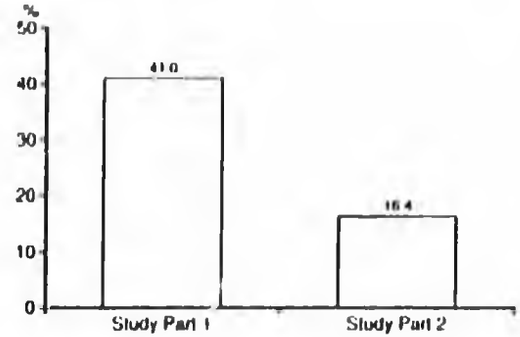


Figure 14

Work-Related Injuries as Percentage of Employed Claimants



Study Part 1 - Claims of $25,000 or More
Study Part 2 - Closed Claim Sample (with Payment Only)

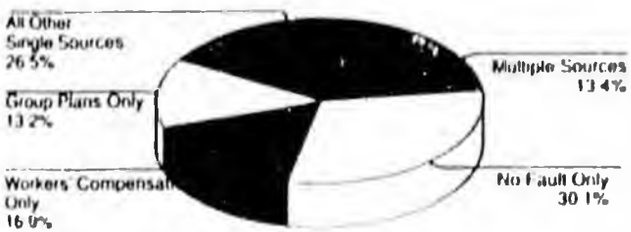
- In Study Part 2, no-fault was the most prevalent collateral source reported, covering over 30 percent of all claimants who had a collateral source reported.

Because of difficulties in collecting collateral source data, the study probably understated the significance of collateral sources. Claimants are generally not required by law to disclose collateral sources—either to insurers or to the courts—and the process of negotiating settlements strongly discourages plaintiffs from volunteering this information.

Figure 15

Distribution of Claims by Type of Collateral Source

Study Part 2 - Closed Claim Sample (With Payment Only)



Thus, collateral source benefits were probably far more widely available than the study found. For example, in 1983, 80 percent of all Americans had private health insurance for hospital expenses, 76 percent had coverage for surgical expenses, and 73 percent had coverage for physicians' expenses. Over 134 million Americans belonged to some form of employer- or union-provided group coverage plan. (See U.S. Bureau of the Census, *Statistical Abstract of the United States: 1987* (107th edition) Washington, DC., 1986, p. 89)

3. Punitive Damages

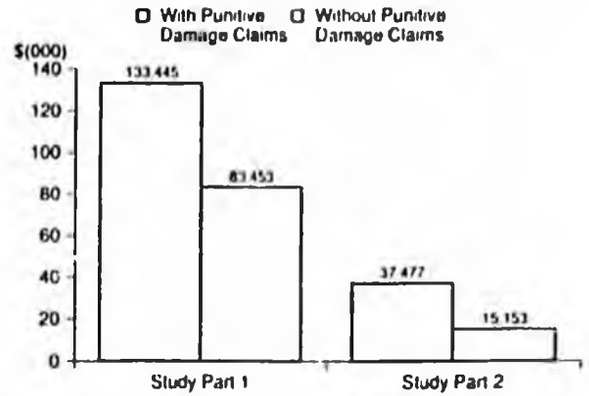
Awards for punitive damages are not designed to compensate for injury but to penalize the defendant for conduct that a court finds to be beyond ordinary negligence. The standards vary from state to state. Some jurisdictions provide damages for gross negligence, others for reckless misconduct, and others for conduct deemed wanton, willful, or malicious.

Since a very small minority of claims actually go to verdict, many observers have argued that award levels as such do not reveal the primary effect of punitive damages. Instead, their main effect comes in the upward ratcheting of settlements negotiated with a threat of potentially large punitive damage awards. In effect, to protect insureds against the risk of large punitive awards, insurers are agreeing to bigger settlements than they would without the threat of punitive damages. The *Claim File Data Analysis* makes an effort to quantify this "shadow effect" of punitive damages awards on actual claim settlements. The relevant findings include the following:

- On average, respondents reported that claim settlements rose about 10 percent when claimants sought punitive damages. In Study Part 1 (claims of $25,000 or more), where claimants sought punitive damages, survey participants reported that the punitive damage claims influenced the settlement in 13 percent of the cases. Among that 13 percent, the respondents reported that compensation would have been 55 percent lower on average if the claimants had not sought punitive damages.
- In Study Part 1, claim settlements where claimants sought punitive damages were about 60 percent higher than those where claimants did not seek punitive damages ($133,000 compared with $83,000). In Study Part 2 (closed claim sample), claim settlements where claimants sought punitive damages were nearly 150 percent higher than those where claimants did not seek punitive damages ($37,000) compared with $15,000). Much of the difference in claim settlement value between claims with and without the threat of punitive damages may have resulted from the inherent characteristics of these claims, rather than the threats. Nevertheless, as the respondents reported, punitive damage claims do have some effect on claim settlements.

Figure 16

Average Losses with and without Punitive Damage Claims



Study Part 1 - Claims of $25,000 or More (Closed Claims Only)
Study Part 2 - Closed Claim Sample (with Payment Only)

E. Governmental and Municipal Claims

State and local governments have asserted that changes in the legal climate have, in effect, converted governments into "deep pockets" for potential claimants. The study, which collected information on approximately 1,000 claims against local governments and municipalities, suggests that this contention has merit. The study found that governmental entities were more likely than other insureds to make settlement payments in excess of their percentages of fault. Claimants against governmental entities were more likely than other claimants to sue and to receive compensation greater than their economic losses.

Specifically for the "all other liability" claims:

- In multi-defendant cases, when the insured was a municipal or governmental entity, the insured's estimated percentage of settlement exceeded its estimated percentage of fault in 46 percent of the cases, compared with 36 percent of the cases for all multi-defendant cases.

- Claimants filed suits in the vast majority of governmental claims—in 75 percent of the small governmental claims and in 88 percent of the large governmental claims. By contrast, in the general claim population, claimants filed suits in only about one third of the claims. The frequency of suits against governmental and municipal entities may be attributable in part to the tight statutory time limits for filing suits against such public entities. Claimants are forced to sue early in the claims process or forgo the right to sue later.

Figure 17

Percentage of Cases in Which Insured's Percentage of Settlement Exceeded Percentage of Fault

"All Other Liability"

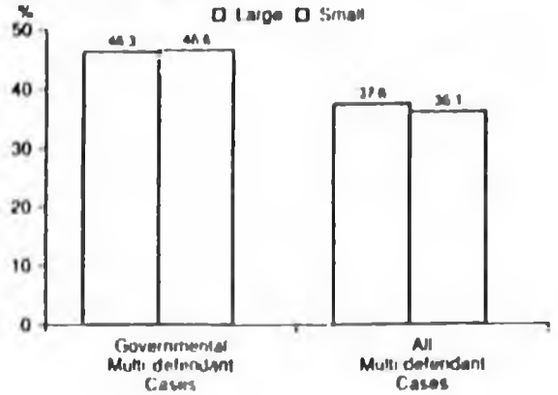
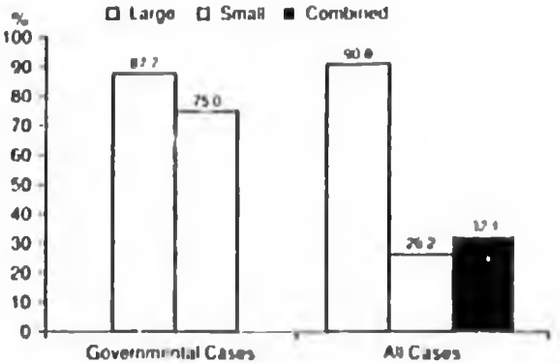


Figure 18

Percentage of Cases with Lawsuit Filed

"All Other Liability"



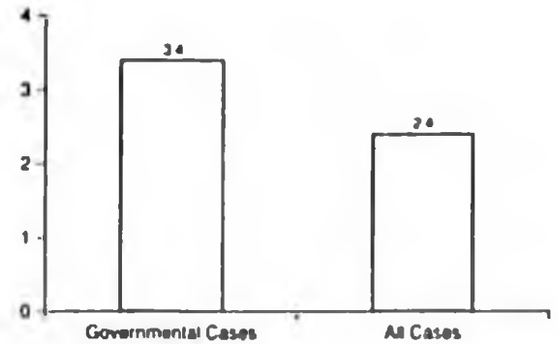
- The tendency for the insurance payment to exceed the claimant's economic loss was significantly stronger for claims against governmental entities than for the general claims population. For governmental claims, average compensation was 3.4 times the average fault-adjusted economic loss, while for the general claim population, compensation was only 2.4 times the fault-adjusted economic loss.

The study may not have captured a representative sample of governmental and municipal claims because of two limitations. First, insurers that participated in the study were not necessarily the ones that wrote the majority of governmental business during the sample periods. And second, many companies did not segregate claims against governmental entities in their claim files.

Figure 19

Ratio of Compensation to Fault-Adjusted Economic Loss

"All Other Liability"



F. Reserving Practices

Insurer reserving practices have been an issue in the recent public debate over the availability and affordability of liability insurance. The study does not address the adequacy of current insurer reserves. It does, however, review differences between initial case reserves and the ultimate payments made by insurers.

Insurers continually review and update their case reserves as better information becomes available. In addition to the individual case reserves, insurers have "bulk" reserves for the expected development of open claims and for claims that have been incurred but have not yet been reported, known as incurred but not reported, or IBNR. Those "bulk" reserves are not included in this analysis.

Findings on reserving practices include the following:

- In the aggregate, Study Part 2 (closed claim sample) claims were initially under-reserved by 26 percent. About 61 percent of the claims were over-reserved by a total of more than $169 million. (Of these claims, about half were closed without payment.) For some claims (11 percent), the initial case reserves *exactly* equaled the ultimate insurance loss. The remaining 28 percent of claims were under-reserved by a total of more than $333 million.

Table 2

Adequacy of Initial Reserves
Study Part 2—Closed Claim Sample

	% of Claims	Initial Reserve minus Ultimate Insurance Loss
Reserve > Loss	60.7%	$16,995,988
Reserve = Loss	11.4	0
Reserve < Loss	27.9	(33,332,663)
Total	100.0%	$(16,336,675)

III. Tort Reform Opinion Survey

In addition to the analyses outlined in Section II, the study also collected the opinions of the participating claims professionals on the effects of tort reforms enacted in recent years.

A. Scope of Survey and Methodology

The opinion survey covered 24 states that enacted some form of tort law change. Each participant was given a description of the relevant tort reforms enacted in the state. The participant was then asked to indicate separately for each statutory provision whether the provision would affect the claim and, if so, to estimate the dollar effect within a broad range.

B. Objectives and Limitations

A full understanding of the conclusions and limitations of the opinion survey requires a reading of Chapter V of the underlying study. Briefly, the objective of the opinion survey was to determine the relative effect and direction of the states' tort law changes on bodily injury indemnity losses and allocated loss adjustment expenses. The study analyzed the percentage of claims estimated to be affected by each tort reform in each state and the estimated dollar effect on individual affected claims.

No attempt was made to quantify a precise dollar impact of each reform. The primary reasons for this are the lack of statistical credibility caused by the small number of claims in most states, the variation in results that could be caused by the presence or absence of a few large claims in a state, and the subjective nature of the judgments requested in the survey forms. The only overall opinions quoted in the study about the effect on total bodily injury indemnity losses are for a few states and tort reforms with a reasonably credible number of claims affected.

Because of the enormous variations in the tort reform laws enacted in the different states, the opinion survey does not permit countrywide generalizations. In addition, in most of the states surveyed, the data is limited and is not credible for drawing precise conclusions.

Nonetheless, particularly when viewed in conjunction with the findings from the *Claim Evaluation Project*, this opinion survey provides valuable insights. The survey represents the first quantitative measure of the percentage of claims likely to be affected by the recent tort reform legislation. Moreover, the term "tort reform" has taken on generic meaning and has come to cover an extraordinary variety of actions. This survey and its predecessor can help distinguish reforms likely to have a powerful effect from those likely to have little effect. Finally, different tort reforms affect different sectors of the claims universe. This survey helps delineate those different effects.

Studies of this nature should help deepen awareness that no simple mathematical formula can calculate the prospective cost implications of tort law changes.

C. Findings

In the aggregate, the study participants estimated that nearly 15% of the claims studied would have been affected by the enacted tort reforms. Moreover, for each category of tort reform – joint and several liability, collateral source rule, and others – at least some states enacted a variant that would have had a meaningful effect in a substantial number of cases. For example, in seven of the states that amended the collateral source rule, 20 percent or more of the large claims studied would have been affected. Furthermore, while the study does not quantify the cost reductions associated with each tort reform, the participants' responses suggest that in claims that would have been affected, the potential cost reduction often would have been substantial.

These findings, coupled with an analysis of the percentages of claims affected, carry several implications. First, the study reinforces the finding of the 1987 *Claim Evaluation Project* that many of the legislative actions falling under the category of tort reform were heavily encumbered by exceptions and qualifications. Whatever their public policy merits, these exceptions and qualifications limit the cost effects of the reforms. Second, while certain classes of tort reform can influence indemnity levels across a broad spectrum of claims, others may have a

powerful effect in a limited range of cases. Certain tort reforms may play an insignificant role in the typical small claim situation – for example, modifications of joint and several liability, restrictions on punitive damages, and ceilings on non-economic damages. However, these same reforms may have greater force in the larger claims, where cost predictability is a special problem for insurers.

The opinion survey indicates that the enacted tort reforms generally would have had a greater effect on large claims (Study Part 1) than on small claims. That disparity was less pronounced in connection with reforms aimed at modifying the collateral source rule. The survey found that changes in the collateral source rule produced the broadest effect in the largest number of states. This finding does not imply that modifications of the collateral source rule are inherently the most powerful tort reform tool for reducing indemnity costs. The survey did not address which hypothetical tort reforms might have produced the greatest cost reductions.

Among the large claims, tort reforms in the area of joint and several liability had powerful effects in two states that repealed the doctrine outright. In those two states, Colorado and Wyoming, participants found that over 15% of all Study Part 1 claims would have been affected.

In most instances, the caps on non-economic damages and restrictions on punitive damages, as enacted, would have affected relatively fewer cases, although in some individual cases the dollar effects appeared potentially large.

The findings about limitations to punitive damages illustrate why aggregate data on the percentage of claims influenced by a given tort reform can understate the effect of the reform. The participants estimated that the enacted punitive damage provisions would have affected only a small sliver of the total claims studied. In the large claim sample (Study Part 1) for the two states reporting the greatest effects, Iowa and Montana, respondents estimated that under 10% of all claims would have been affected. However, claimants sought punitive damages in 10% of the Study Part 1 closed claims. So the projected effects of the recent legislation appear far more impressive. In short, in the states that enacted strong laws on punitive damages, the opinion survey finds powerful effects among the small, but important, minority of claims where punitive damages are an issue.

IV. Additional Study Specifications

A. Participating Insurer Groups

Listed below are the 24 insurer groups whose submissions make up the data base underlying this study.

Aetna Life & Casualty
American International Group, Inc.
Chubb Group of Insurance Companies
CIGNA Property and Casualty Companies
CNA Insurance Companies
Continental Insurance
Crum & Forster Insurance Companies
Fireman's Fund Insurance Companies
General Accident Insurance Company of America
Great American Insurance Company
The Hartford Insurance Group
Home Insurance Company
Imperial Casualty and Indemnity Company
The Kemper National Property and Casualty Companies
Liberty Mutual Insurance Company
Lincoln National Corporation
Nationwide Insurance Companies
(including) Wausau Insurance Companies)
The Reliance Insurance Companies
Royal Insurance USA
St. Paul Companies
State Farm Insurance Companies
The Travelers Insurance Company, Inc.
United States Fidelity & Guaranty Company
Zurich American Insurance Group

B. States Surveyed

Listed below are the 27 states surveyed in this study. During 1986, 24 of the states enacted some modification to their tort laws affecting the settlements of commercial liability claims other than medical malpractice. Three states —Kansas, Massachusetts, and South Dakota—were surveyed to balance the geographic mix of states.

Alaska
California
Colorado
Connecticut
Florida
Georgia
Hawaii
Illinois
Indiana
Iowa
Kansas
Louisiana
Maryland
Massachusetts
Michigan
Minnesota
Montana
New Hampshire
New York
Ohio
Oklahoma
South Carolina
South Dakota
Utah
Washington
West Virginia
Wyoming

C. Lines of Business Included

The study included all direct business, including, but not limited to, monoline, package, national accounts, and surplus lines written by the 24 participating insurers. Umbrella and excess policies were excluded. The bodily injury liability portions of the following lines of insurance were examined: premises/operations (e.g., OL&T, M&C, Businessowners), product liability, and commercial automobile.

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: HB 166
PUBLISH DATE:

FISCAL NOTE

REQUEST:

Revision Date:
Title: An Act relating to civil actions amending Civil Rules 68 and 82
Sponsor: Cotten
Requester: Labor & Commerce

Agency Affected: Commerce & Economic Dev.
BRU: Division of Insurance
Components: Operations

EXPENDITURES / REVENUES : (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL		350.0	300.0	250.0	100.0	100.0
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING		350.0	300.0	250.0	100.0	100.0
CAPITAL						
REVENUE						

FUNDING: (Thousands of dollars)

GENERAL FUND		350.0	300.0	250.0	100.0	100.0
FEDERAL FUNDS						
OTHER						
TOTAL		350.0	300.0	250.0	100.0	100.0

POSITIONS:

FULL-TIME		0	0	0	0	0
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary.)

See attached

Prepared by: Don Koch, Chief of Market Surveillance
Division: Insurance
Phone: 465-2515
Date:

Approved by Commissioner: Larry Merculieff
Agency: Department of Commerce & Economic Development
Phone: 465-2500
Date:

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

3527D-2/031089a

ANALYSIS:

Section 18 requires an analysis of medical malpractice rate changes occurring as a result of court decisions in the state involving personal injury or death. This requires a review that present staff lacks the needed expertise to conduct. We estimate that such a review could be conducted by an independent actuarial firm. This review is structured as ongoing, hence, we have estimated $110,000 per year for this work. The depth of review would be subject to negotiation and design.

Section 21 requires an extensive review with a report due by February 1992. The report would review closed insurance claims to determine the impact of the legal system on increased insurance rates or coverage decreases in crisis lines which are not defined. It would further evaluate how victims are faring under the present system and the actual impact of tort reform measures adopted. It would review actual impact on this legislation on insurance rates.

Section 21 also provides for a study of insurance finances to evaluate the cost justification of insurance rates for fault based on personal injury, death or property damage awards, settlements and court decisions. This requires considerable actuarial, economic, and legal evaluation which the Division of Insurance is not capable of providing. Initial design will result in increased expense in the first year. These figures are estimates that can only be refined through a proposal from persons capable of conducting such a study.

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CSHB 166 (L&C)
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: 3/5/90
Title: An Act relating to civil actions amending Civil Rules 68 and 82
Sponsor: Cotten
Requestor: Judiciary

Agency Affected: Commerce & Economic Dev.
BRU: Insurance
Component: Operations

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL	350.0	300.0	250.0	110.0	110.0	110.0
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	350.0	300.0	250.0	110.0	110.0	110.0
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND	350.0	300.0	250.0	110.0	110.0	110.0
FEDERAL FUNDS						
OTHER						
TOTAL	350.0	300.0	250.0	110.0	110.0	110.0

POSITIONS:

FULL-TIME	0	0	0	0	0	
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary) No fiscal impact in FY 90.

See attached

Prepared by: Joan Brown, Administrative Officer
Division: Insurance
Phone: 465-2597
Date: _____

Approved by Commissioner: Larry Merculieff
Agency: Department of Commerce & Economic Development
Date: 3/6/90

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

6356D-1/3690d

ANALYSIS:

Section 12 requires an analysis of medical malpractice rate changes occurring as a result of court decisions in the state involving personal injury or death. This requires a review that present staff lacks the needed expertise to conduct. We estimate that such a review could be conducted by an independent actuarial firm. This review is structured as ongoing, hence, we have estimated $110,000 per year for this work. The depth of review would be subject to negotiation and design.

Section 14 requires an extensive review with a report due by February 1992. The report would review closed insurance claims to determine the impact of the legal system on increased insurance rates or coverage decreases in crisis lines which are not defined. It would further evaluate how victims are faring under the present system and the actual impact of tort reform measures adopted. It would review actual impact on this legislation on insurance rates.

Section 14 also provides for a study of insurance finances to evaluate the cost justification of insurance rates for fault based on personal injury, death or property damage awards, settlements and court decisions. This requires considerable actuarial, economic, and legal evaluation which the Division of Insurance is not capable of providing. Initial design will result in increased expense in the first year. These figures are estimates that can only be refined through a proposal from persons capable of conducting such a study.

Ketchikan General Hospital
3100 TONGASS AVE.
KETCHIKAN, ALASKA 99901
PHONE 907-225-5171
FAX 907-225-2173

DATE: March 16, 1990

TO: Representative Gruenberg
Chairman House Judiciary Committee

FROM: Governing Board - Ketchikan General Hospital

RE: TORT REFORM - House Bill 166

The Governing Board of Ketchikan General Hospital strongly supports HB 166.

We have reviewed documents from Medical Insurance Exchange of California, which indicates that meaningful tort reform expressed by California's Medical Injury Compensation Reform Act has moderated rate increases in Alaska. The tort reforms which have moderated malpractice claims are MICRA's changes to the collateral source rule, limits on non-economic damages, periodic payments of awards, and limits on attorneys' contingency fees.

The Governing Board of Ketchikan General Hospital goes on record supporting HB 166

Edward Mahn, Chairman
Maxine Robertson, Vice Chair
Judge Henry Keene, Secretary
Walter Shuham
Ethelbelle Kondzela
Roger Stone

KGH

KETCHIKAN MEDICAL SOCIETY

3100 TONGASS AVENUE - KETCHIKAN, ALASKA 99901

DATE: March 16, 1990

TO: Representative Gruenberg
Chairman House Judiciary Committee

FROM: Philip Zeidner, M. D., Vice Chairman, Ketchikan Medical Society

RE: TORT REFORM - HB 166

I appreciate the opportunity to have given testimony supporting passage of HB166. Enclosed is a copy of MIEC's letter to Alaska physicians dated May 10, 1989. MIEC's loss ratio clearly indicates a large differential between Alaska claims frequency and size of award compared to their overall loss ratio for policy holders in different states. It is MIEC's opinion, as expressed in paragraph two, page two, that California's Medical Injury Compensation Reform Act has been a factor in moderating rate increases for California. "The tort reforms which have moderated malpractice claims are MICRA's changes to the collateral source rule, limits on non-economic damages, periodic payment of awards, and limits on attorneys' contingency fees".

I strongly urge the committee to recognize that part of the high cost of medical liability insurance in the State of Alaska is due to our current tort system. Meaningful tort reform has been shown to have mitigated insurance rates for physicians in California.

MIEC

Medical Insurance Exchange of California
Medical Underwriters of California

May 10, 1989

MEMORANDUM TO ALASKA POLICYHOLDERS REGARDING RENEWAL RATES

(Policy Year August 1, 1989 to July 31, 1990)

This is to inform you that effective August 1, 1989, MIEC's basic rates for Alaska will be increased 11.7%. MIEC's recent loss experience in Alaska shows a continuing increase in the frequency and severity of claims, to the point where Alaska's claims now average almost twice the size, and about 35% greater frequency than for the company as a whole. Attached are graphs which compare Alaska's and MIEC's overall claims frequencies, severities and loss ratios for two recent five-year blocks of time.

In addition to this increase in basic rates, those doctors insured less than five years also will receive the step rate increases which occur as claims-made discounts diminish each year until the fifth, when the mature claims-made rate is attained. Some step-rate increases, and the 11.7% basic rate increase, will be modified by the following company-wide specialty classification changes:

- Cardiologists who do not perform catheterization or angioplasty by a 13% reduction. Rates of cardiologists who do perform these procedures will increase by 30.4%, in addition to the 11.7% basic rate increase. Cardiologists who conduct invasive procedures have incurred 90% of claims costs of all cardiologists MIEC insures. Over six years of combined claims experience, cardiology losses have been 39% higher than those of all non-surgical specialties. MIEC continues loss-prevention activities with this specialty through claims analysis, on-site visits, and office consultations.
- Family and general practitioners who do no surgery will receive a 10% rate reduction; those who do limited surgery and assist, a 14.3% reduction; and those who do surgery but no obstetrics, a 30.6% reduction.
- Physical medicine and rehabilitation specialists will receive a 10% rate reduction.
- Industrial medicine specialists will receive a 30.6% rate reduction.

The changes in classification result from MIEC's continuing analysis of loss patterns among specialties and MIEC's long-standing policy to adjust premiums to the relative losses of various specialties.

We are pleased to announce that because of reduced reinsurance costs, MIEC is able to lower the charges for limits of liability in excess of $1,000,000/$3,000,000 in many classifications. If you are interested in obtaining a quotation for either the $2,000,000/$4,000,000 or $5,000,000/$5,000,000 limits options, please call MIEC's Underwriting Department.

MIEC has been insuring Alaska physicians since 1978, and is Alaska's only doctor-owned, medical society-sponsored carrier. Physician ownership means physician direction of policy, physician peer review, active loss prevention, policy control over claims and underwriting, equitable treatment of policyholders, proper investigation, and vigorous, steadfast defense of claims through knowledge and experience in medical professional liability. MIEC is rated A+ by A.M. Best Company, the insurance industry rating service.

MIEC supports Alaska State Medical Association's ongoing efforts to achieve more meaningful tort reform. California's Medical Injury Compensation Reform Act (MICRA), combined with MIEC's loss prevention activities, have moderated rate increases there. The tort reforms which have moderated malpractice claims are MICRA's changes to the collateral source rule, limits on noneconomic damages, periodic payments of awards, and limits on attorneys' contingency fees.

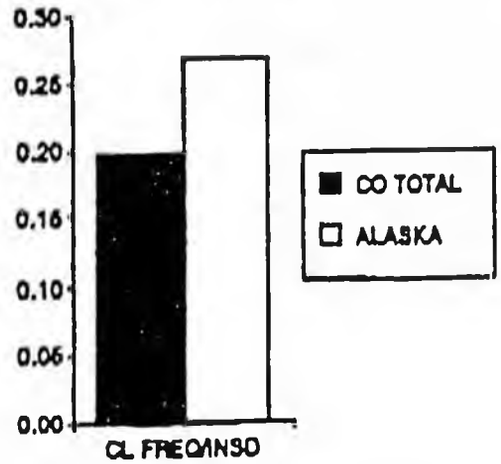
Upon approval of the new rates by the Alaska Insurance Division, premium invoices for renewal will be sent to policyholders in late June. If you have questions about these changes or wish to change your coverage limits or classification, please contact MIEC's Underwriting Department.

Sincerely,

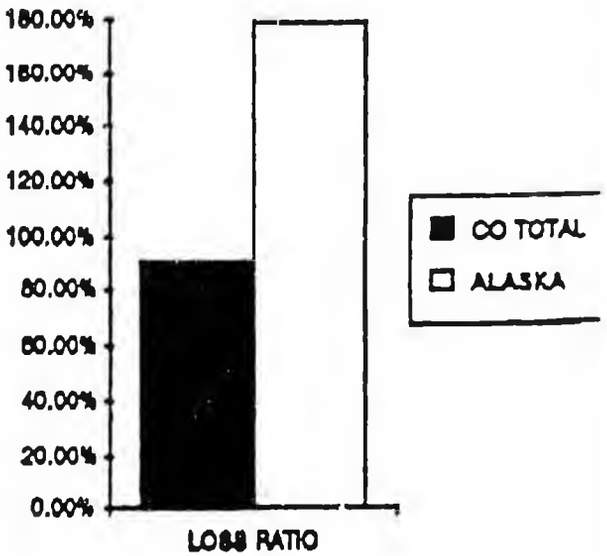
Board of Governors, Medical Insurance Exchange of California
Board of Directors, Medical Underwriters of California

MIEC

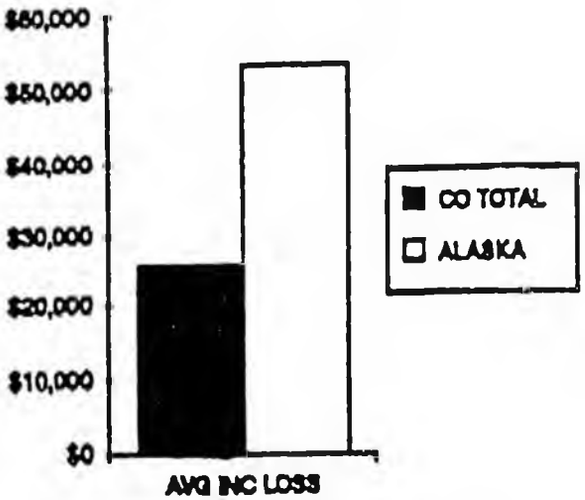
Medical Insurance Exchange of California
Medical Underwriters of California



1982/86 POLICY YEARS COMBINED
CLAIM FREQUENCY PER INSURED PER YEAR:
MIEC TOTAL AND ALASKA COMPARED



1982/86 POLICY YEARS COMBINED
LOSS RATIOS: MIEC TOTAL
AND ALASKA COMPARED



1982/86 POLICY YEARS COMBINED
AVERAGE INCURRED LOSS: MIEC TOTAL
AND ALASKA COMPARED

STRUCTURED
FINANCIAL
ASSOCIATES, INC.

A. L. TAMAGNI, SR.

ANCHORAGE, ALASKA OFFICE
238 H STREET • SUITE 100
ANCHORAGE, ALASKA 99501
907-276-1973 • WITHIN ALASKA 800-478-1973

OFFICES:
ANCHORAGE
ATLANTA
BALTIMORE
BOSTON
BUTTE
CARMEL
CHICAGO
COLUMBIA
COLUMBUS
DENVER
DETROIT
HAWAII
KANSAS CITY
MILL VALLEY
ORLANDO
PHILADELPHIA
PHOENIX
PITTSBURGH
RICHMOND
SAN DIEGO

March 22, 1990

Representative Peter Goll
Alaska State Legislature
P.O. Box V (MS 3100)
Juneau, Alaska 99811

Hayden Acknowledged

RE: HB 166
VERSION 6-0628A

HB 166
CS L&C VERSION 6-0628D

Dear Representative Goll:

I appreciate the opportunity in testifying to your committee during the past week in regards to the above bill and its amended versions. I have some recommended changes on certain portions of the bill. I believe that version C-0628A is the better version.

In addition to the language, we have stated the recommendations and reasons. Accordingly, the following is in order:

I

COMMENTS OF THE NATIONAL STRUCTURED SETTLEMENT TRADE ASSOCIATION OF HB 166 DRAFT 60628A

The section numbers below correspond to the section numbers of the proposed bill:

SECTION 1 (G) ADDITION — Statement of purpose

Recommendation. The legislative finds should be expanded. For example, the legislature should find that the compensation to victims should be paid at the time future damages accrue in order to reduce the burden on public assistance programs caused by the dissipation of lump-sum awards. As a further example, the legislature should find that the United States Internal Revenue Code and the State of Alaska allows the plaintiff to exclude from income the entire amount of future periodic payments so that the amount recovered can have greater recovery effect, and the cost to make such payments be reduced through periodic payments, particularly those utilizing qualified funding assets.

Reasons. The proposed legislative findings are directed to the relief of defendant's costs and obligations. The additional findings will enhance the constitutionality of the legislation. Constitutional attacks on periodic payment legislation often focus on the equal protection clause of the Constitution. In examining legislative classifications for equal protection purposes, courts ask whether those classifications are reasonable and have a fair and substantial relation to the object of the legislation. For those legislators and courts that wish to see greater benefits articulated in order to justify the restriction on recoveries of future damages to periodic payments, the enumeration of the additional findings will increase the likelihood of a finding of constitutionality.

II

SECTION 8. AS 09.17.040(D) Changed to read as follows:

In an action to recover future damages the trier of fact at the request of any party, enter judgment ordering that amounts be paid to the maximum extend feasible by periodic payments, rather than by a lump sum payment. If a portion of the judgment awarded is owed to an attorney under a contingent fee agreement, that portion of the judgment shall be reduced to present value and paid in a lump sum.

A. Reasons For due process reasons, the section is elective by either the defendant or plaintiff. If the plaintiff elects to utilize the request, then the defendant can defeat the request unless the plaintiff shows that future damages will be awarded. The defendant can elect to utilize the section with a showing that funding for the periodic payments can be provided.

B. Reasons
These changes will achieve the intent of the legislature, to allow due process by all parties and allow Judges and Juries to hear evidence and types of offers for settlement that is now lacking under the current process. It will expedite the settlement of cases, help reduce the court backlog, reduce legal costs, and allow a greater percentage of the total recovery to injured parties.

C. Reasons
For taxation purposes, both parties have equal access to request the trier of fact to order future payments on a favorable tax basis under Section 104(A)(2), attached Exhibit "A".

III

SECTION 9 AS 09.17.040 (f) Changed to read as follows:

A judgment ordering payment of future damages by periodic payment shall specify the recipient, the dollar amount of the payments, including any fixed increases in future payments for anticipated inflation, the interval between payments, and the number of payments or the period of time over which payments shall be made. Payments may be modified only in the event of the death of the judgment creditor, in which case payments may not be reduced or terminated, but shall be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately before death. In the event the judgment creditor owed no duty of support to dependents at the time of the judgment creditor's death, the money remaining shall be distributed in accordance with a will of the deceased judgment creditor accepted into probate or under the intestate laws of the state if the deceased had no will.

Recommendation. The inflation indexing concept should be replaced by a stated percentage to be fixed by the trier of fault.

A. Reasons. First, the inflation index will fluctuate with economic conditions. Annuity underwriters are accustomed to a fixed index, the effect of which can be calculated with certainty when the annuity is issued. There may be little or no market available to Casualty Insurers, Plaintiffs, and Self-Insured Defendants for the type of annuity needed to fund a judgment that is adjusted by an unknown factor.

B. Reasons. Section 130(c)(2)(A) of the Internal Revenue Code of 1986, as amended, requires that periodic payments be fixed and determinable in order for an assignee to enjoy the exclusion described in that section. Payments that increase by a stated percentage are fixed and determinable while payments that increase by an index are not. Thus, the court

should be allowed to make adjustments only by a stated percentage, to be determined based upon the facts of each case.

C. See attached Section 104.A.2 IRS Code. Exhibit "A".

I would appreciate your considering these recommendations in the output of your final bill. I would be available for any questions you might have regarding these recommendations, either personally or by committee.

Very truly yours,

A. L. Tamagni, Sr.

Enclosures

"(2) First time homebuyer requirement.—The amendments made by subsection (c) [amending subsec. (e)] shall also apply to obligations issued after April 24, 1979, and before the date of the enactment of this Act [Sept. 3, 1982] but only to the extent that the proceeds of such obligations are not committed as of the date of the enactment of this Act [Sept. 3, 1982]."

For effective dates of further amendments to this section by Pub.L. 97-248 with respect to applicability to obligations issued after December 31, 1982, see section 310(d) of Pub.L. 97-248.

Effective Date of 1980 Amendment. Pub.L. 96-595, § 5(c), provided that the amendment by Pub.L. 96-595 shall take effect as if included in the amendments made by section 1102 of Pub.L. 96-499.

Effective Date. Pub.L. 96-499, § 1104, as amended by Pub.L. 97-248, § 221(e)(2), provided that, except as otherwise provided in section 1104(a)(2) through (e)(2) of Pub.L. 96-499, this section shall apply to obligations issued after Apr. 24, 1979.

§ 104. Compensation for injuries or sickness

(a) In general.—Except in the case of amounts attributable to (and not in excess of) deductions allowed under section 213 (relating to medical, etc., expenses) for any prior taxable year, gross income does not include—

(1) amounts received under workmen's compensation acts as compensation for personal injuries or sickness;

(2) the amount of any damages received (whether by suit or agreement and whether as lump sums or as periodic payments) on account of personal injuries or sickness;

(3) amounts received through accident or health insurance for personal injuries or sickness (other than amounts received by an employee, to the extent such amounts (A) are attributable to contributions by the employer which were not includible in the gross income of the employee, or (B) are paid by the employer);

(4) amounts received as a pension, annuity, or similar allowance for personal injuries or sickness resulting from active service in the armed forces of any country or in the Coast and Geodetic Survey or the Public Health Service, or as a disability annuity payable under the provisions of section 808 of the Foreign Service Act of 1980; and

(5) amounts received by an individual as disability income attributable to injuries incurred as a direct result of a violent attack which the Secretary of State determines to be a terrorist attack and which occurred while such individual was an employee of the United States engaged in the performance of his official duties outside the United States.

For purposes of paragraph (3), in the case of an individual who is, or has been, an employee within the meaning of section 401(c)(1) (relating to self employed individuals), contributions made on behalf of such individual while he was such an employee to a trust described in section 401(a) which is exempt from tax under section 501(a), or under a plan described in section 403(a), shall, to the extent allowed as deductions under section 404, be treated as contributions by the employer which were not includible in the gross income of the employee.

(b) Termination of application of subsection (a)(4) in certain cases.—

(1) In general.—Subsection (a)(4) shall not apply in the case of any individual who is not described in paragraph (2).

(2) Individuals to whom subsection (a)(4) continues to apply.—An individual is described in this paragraph if—

(A) on or before September 24, 1975, he was entitled to receive any amount described in subsection (a)(4),

(B) on September 24, 1975, he was a member of any organization (or reserve component thereof) referred to in subsection (a)(4) or under a binding written commitment to become such a member,

(C) he receives an amount described in subsection (a)(4) by reason of a combat-related injury, or

(D) on application therefor, he would be entitled to receive disability compensation from the Veterans' Administration.

(3) Special rules for combat-related injuries.—For purposes of this subsection, the term "combat-related injury" means personal injury or sickness—

(A) which is incurred—

(i) as a direct result of armed conflict,

(ii) while engaged in extrahazardous service, or

(iii) under conditions simulating war; or

(B) which is caused by an instrumentality of war.

In the case of an individual who is not described in subparagraph (A) or (B) of paragraph (2), except as provided in paragraph (4), the only amounts taken into account under subsection (a)(4) shall be the amounts which he receives by reason of a combat-related injury.

(4) Amount excluded to be not less than veterans' disability compensation.—In the case of

"(2) First time homebuyer requirement.—The amendments made by subsection (c) [amending subsec. (e)] shall also apply to obligations issued after April 24, 1979, and before the date of the enactment of this Act [Sept. 3, 1982] but only to the extent that the proceeds of such obligations are not committed as of the date of the enactment of this Act [Sept. 3, 1982]."

For effective dates of further amendments to this section by Pub.L. 97-248 with respect to applicability to obligations issued after December 31, 1982, see section 310(d) of Pub.L. 97-248.

Effective date of 1980 Amendment. Pub.L. 96-595, § 5(c), provided that the amendment by Pub.L. 96-595 shall take effect as if included in the amendments made by section 1102 of Pub.L. 96-499.

Effective Date. Pub.L. 96-499, § 1104, as amended by Pub.L. 97-248, § 221(c)(2), provided that, except as otherwise provided in section 1104(a)(2) through (a)(2) of Pub.L. 96-499, this section shall apply to obligations issued after Apr. 24, 1979.

§ 104. Compensation for injuries or sickness

(a) In general.—Except in the case of amounts attributable to (and not in excess of) deductions allowed under section 213 (relating to medical, etc., expenses) for any prior taxable year, gross income does not include—

(1) amounts received under workmen's compensation acts as compensation for personal injuries or sickness;

(2) the amount of any damages received (whether by suit or agreement and whether as lump sums or as periodic payments) on account of personal injuries or sickness;

(3) amounts received through accident or health insurance for personal injuries or sickness (other than amounts received by an employee, to the extent such amounts (A) are attributable to contributions by the employer which were not includible in the gross income of the employee, or (B) are paid by the employer);

(4) amounts received as a pension, annuity, or similar allowance for personal injuries or sickness resulting from active service in the armed forces of any country or in the Coast and Geodetic Survey or the Public Health Service, or as a disability annuity payable under the provisions of section 808 of the Foreign Service Act of 1980; and

(5) amounts received by an individual as disability income attributable to injuries incurred as a direct result of a violent attack which the Secretary of State determines to be a terrorist attack and which occurred while such individual was an employee of the United States engaged in the performance of his official duties outside the United States.

For purposes of paragraph (3), in the case of an individual who is, or has been, an employee within the meaning of section 401(c)(1) (relating to self-employed individuals), contributions made on behalf of such individual while he was such an employee to a trust described in section 401(a) which is exempt from tax under section 501(a), or under a plan described in section 403(a), shall, to the extent allowed as deductions under section 404, be treated as contributions by the employer which were not includible in the gross income of the employee.

(b) Termination of application of subsection (a)(4) in certain cases.—

(1) In general.—Subsection (a)(4) shall not apply in the case of any individual who is not described in paragraph (2).

(2) Individuals to whom subsection (a)(4) continues to apply.—An individual is described in this paragraph if—

(A) on or before September 24, 1975, he was entitled to receive any amount described in subsection (a)(4),

(B) on September 24, 1975, he was a member of any organization (or reserve component thereof) referred to in subsection (a)(4) or under a binding written commitment to become such a member,

(C) he receives an amount described in subsection (a)(4) by reason of a combat-related injury, or

(D) on application therefor, he would be entitled to receive disability compensation from the Veterans' Administration.

(3) Special rules for combat-related injuries.—For purposes of this subsection, the term "combat-related injury" means personal injury or sickness—

(A) which is incurred—

(i) as a direct result of armed conflict,

(ii) while engaged in extrahazardous service, or

(iii) under conditions simulating war; or

(B) which is caused by an instrumentality of war.

In the case of an individual who is not described in subparagraph (A) or (B) of paragraph (2), except as provided in paragraph (4), the only amounts taken into account under subsection (a)(4) shall be the amounts which he receives by reason of a combat-related injury.

(4) Amount excluded to be not less than veterans' disability compensation.—In the case of

OCCUPATIONAL MEDICAL ASSOCIATES

3710 East 20th Avenue
Anchorage, Alaska 99508
Telephone: (907) 258-5800

Jennifer H. Christian, M.D., M.P.H.

March 14, 1990

Rep. Peter Goll
Co-Chair, House Judiciary Committee
P. O. Box V (MS 3100)
Juneau, AK 99811

Dear Representative Goll:

We met during the Alaska State Medical Association's visit to Juneau in February. I enjoyed talking with you then, and hope our conversation was the beginning of an on-going dialogue.

Today, my request is simple: Please pass the Tort Reform Bill out of your committee and let the House vote on it. It seems inconsistent for a person of your ethical principles to allow the bottling up of this issue. The voters of Alaska gave you a clear mandate to reform the tort law at the polls last November. Please let the House, which represents all the people, and all the "interests" act on HB 166.

I also would like to share my personal viewpoint on tort reform. As I see it, tort reform will help keep Alaska doctors committed to their patients and to good medicine. A national study showed that 44% of doctors today say they wouldn't enter medicine if they had it to do over again.

Please find enclosed an editorial I wrote recently for Alaska Medicine. We in organized medicine are trying to develop coping mechanisms and support physicians under pressure. We would rather prevent unmerited or inflated attacks on physicians who

are merely mortal and trying to do their best. Eighty to ninety percent, roughly, of malpractice suits are without merit. That means four out of five doctors who are sued may become frightened, excessively cautious, and distrustful of their other patients unnecessarily. The reality is that malpractice suits have emotional reverberations that far exceed their financial ones. To look at malpractice as a financing mechanism or a social justice issue is to ignore its powerful impact on physicians' willingness to make commitments, make decisions, and take the right action on behalf of patients and society.

This is the other element of tort reform I'm interested in. The ease and lucrativeness of lawsuits makes doing the "right thing" more difficult.

* Would you risk displeasing a patient by denying them a medicine or a treatment or an unnecessary operation they insist they need? That kind of demanding patient may sue.
* Would you speak out publicly against another doctor with unethical or unsound practices? That doctor may sue. Better to let the public take its chances than to protect the public and pay the costs of a lawsuit out of your own pocket.
* Would you serve on a board, a panel, or a committee to confront some difficult problem, (like reviewing the quality of other doctor's work, or setting minimum standards for membership or other privileges, or confronting alcoholic or drug-addicted physicians) when the price of your public service may be the costs of defending yourself against a lawsuit?
* Would you agree to take care of social deviant or poor or mentally ill or other unfortunate patients who cannot pay, who may be unattractive or difficult to deal with, or may not be grateful, or will not follow orders and cooperate with treatment, and then will sue you because they didn't like how you treated them?

If you would do all these things, despite the threats, how long could you keep it up? These days, each of us expects an average

of at least one lawsuit. Could you keep trusting and doing the right thing even after you were sued by a patient you had done your fallible best for?

Malpractice insurance rates vary widely from state to state. It is not biology, or human nature or physician competency that varies across states -- it is the law, and the culture of litigiousness. Please see the attached xerox of a chart showing malpractice premiums by state.

As we shared with you in Juneau, 24% of Alaskan physicians are now practicing medicine "bare", mostly because their practice cannot absorb the fee raises that the additional overhead of a malpractice premium would add. In the bush, 56% are practicing "bare". Many more doctors have stopped doing important procedures or delivering babies because of the increased cost of malpractice insurance coverage for those things. In many cases, the premium would add $1000 or more per operation or delivery. Most of these doctors will not remain in practice if they are sued. Can we lose more physicians in Alaska, especially in the bush? We already have one of the worst physician/population ratios in the country.

The main reason we need tort reform in Alaska is because Alaska needs doctors. Alaska is competing with 50 other states for new physicians. Will those new physicians look favorably to Alaska? Alaska is a tough place to recruit high quality doctors for. Some doctors make high incomes here, but many do not. The state needs doctors who want to establish a good steady practice in a community that needs them, not temporary doctors who are lured by high incomes and punitive conditions. Alaska cannot change its climate, or isolation, or population distribution, but we can make practicing here more comfortable and certain, both financially and emotionally.

Perhaps it would put my statements in better context if I tell you a bit more about myself. I have been in Anchorage for three years. I am the public health physician for the Municipality of

Anchorage, and work about half time. I am also in parttime private practice as the only certified specialist in occupational medicine in the state. I see patients with work-related injuries and toxic or chemical exposures. My private practice is tiny (about one patient per week), and has not broken even financially after a year and a half of effort. The cost of my malpractice insurance last year was $2230. I pay such a low rate because I see patients less than 12 hours per week and occupational physicians have a very low risk of being sued. The combined income from these two activities is less than what I would earn working full time for the city, but I have a skill (occupational medicine) the community needs and I love working with my patients. My husband contributes most of the support to our family, so that I can keep practicing and doing what I love. I am also this year's Anchorage Medical Society president, and secretary-treasurer for the Alaska State Medical Association.

The purpose of the above personal information is for you to see that I am not a rich doctor complaining about my own high overhead. By luck, I sit in several chairs that have let me see the social consequences of unrestrained litigiousness, as well as feel the personal and emotional drain that it produces, and foretell the impact on the health of Alaskans in the future.

Do you want to talk to me? If so, please give me a call at 343-6718 in the mornings at the Anchorage Department of Health and Human Services.

Sincerely yours,

Jennifer Christian

Jennifer Christian, MD, MPH

Enclosures - 2

MICRA: Thirteen Years of Experience Who Needs More Proof?

A recent study of mature claims-made rates of 34 doctor-owned insurance companies in 33 states and the District of Columbia by Dick Layton, consultant to Physicians' Insurers Association of America, shows a striking difference between California's rate trends and those of the rest of the country, and dramatically demonstrates the efficacy of California's "MICRA" tort reforms enacted in 1975. In that year, California's rates were among the highest in the nation, and most commercial insurers fled the state.

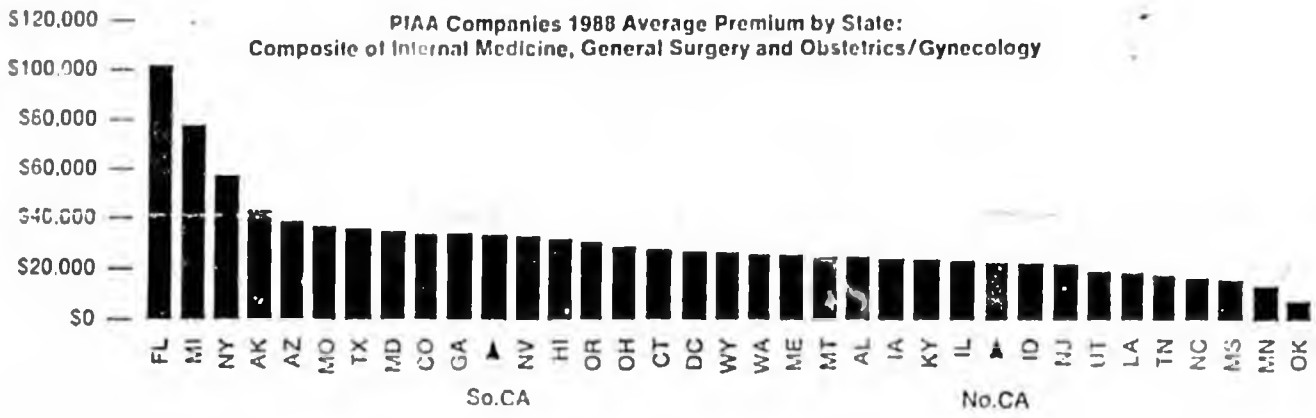
The study compared 1987 and 1988 rates nationwide for internists, general surgeons, and Ob/Gyns. The companies studied are doctor-owned, not-for-profit. They set rates taking investment income into consideration and to cover no more than losses and expenses.

In 1988, rates of the California doctor-owned companies combined for all three specialties fall generally into the bottom half of the nationwide range of rates. Actual net costs to California doctors are still lower than reflected in this comparison because the California companies are paying dividends to long-term policyholders. In MIEC's case, current dividends reduce fifth-year California premiums by an average of 24%.

California internists pay $5,400 to $5,900 for $1 million/3 million coverage, about half what Arizona and Alaska internists pay, and less than a third of Michigan, Florida, and New York rates.

The differences are wider in the surgical categories: California general surgeons pay an average of $25,000 in 1988 prior to dividends. General surgeons in Miami, Florida pay $99,503, a difference of almost $75,000! New York's surgeons pay $59,088, Michigan's $81,209. Missouri and Texas rates exceed $50,000. Some states regarded as "lower risk" pay rates over $30,000, including Ohio, Georgia, Maine, Colorado, Kentucky and Oregon.

While California Ob/Gyn rates have remained in the $40,000-range for several years, premiums over $180,000 exist in Florida, $136,000 in Michigan and $100,000 in New York. Many other states' Ob/Gyn rates have climbed beyond $50,000, as illustrated in the chart below.



Another California Dividend:

The MIEC Board of Governors at its August meeting declared a $2-million dividend to be paid to individual California policyholders who were insured by MIEC during the period August 1, 1979 to December 31, 1984, and who remain insured on February 1, 1989. The dividend will be credited against February and May 1989 quarterly premiums and will reduce net premium costs of eligible California policyholders by an average of 24%. MIEC's current loss ratio for California during the five-year base period used to determine dividend allocation was 69.74%, as opposed to 83.75% for MIEC as a whole. Loss ratios in MIEC's other states are now beginning to drop due to increased premiums, and probably due to loss prevention activities and public attention to tort reform.

ALASKA MEDICINE is owned and published by the Alaska State Medical Association. The American Society for Circumpolar Health and Alaska Public Health Association have designated ALASKA MEDICINE as their official scientific journal.

ALASKA MEDICINE does not hold itself responsible for statements made by any contributor. Statements or opinions expressed in ALASKA MEDICINE reflect the views of the author(s) and not the official policy of the Alaska State Medical Association unless so stated.

Although all advertising material is expected to conform to ethical standards, acceptance does not imply endorsement by ALASKA MEDICINE.

ALASKA MEDICINE is printed by A-1 Publishing, Inc., 1041 E 76th Ave., Suite C, Anchorage, Alaska 99518. Copyright 1988 Alaska State Medical Association.

EDITORIAL BOARD
Donald R. Rogers, M.D.
George Garnett, M.D.
Steve Tucker, M.D.
Richard Witt, M.D.
Rodman Wilson, M.D.

PRODUCTION EDITOR
Verna J. Paluba

BUSINESS AND ADVERTISING
Alaska State Medical Association
4107 Laurel Street
Anchorage, AK 99508

SUBSCRIPTION PRICE: $30 per year
Single copies: $8.00 each

Guest Editorial

A REFUGE FROM IMPOSSIBLE EXPECTATIONS

Even though they promise us excellent work, we don't persecute good carpenters who hang an occasional door backwards. We ask them to pay for the replacement and hang it again. We don't impeach the politicians who include loopholes in even good laws. We don't blackball stockbrokers who give us one bum suggestion along with the good ones. And yet, the public repudiates physicians who cannot bat 1.000. And what's worse, we physicians agree with these impossible expectations by deluding ourselves that we are different, and can extract continuous perfect performance from ourselves.

Biologically we are made of the same material that carpenters, politicians and stockbrokers are. Our span of concentration is prone to the same lapses. We can be overconfident or distracted. We can mishear, misunderstand, misread. We can be too proud to admit we don't know or understand. We can be dulled by alcohol, drugs, or other compulsions. Money troubles or similar "outside" influences can pressure us to compromise our own standards. We can be too tired to make a good decision, or too emotionally involved to see the situation fairly.

The standards set for us are higher than for other professions, but we are made of the same fallible stuff. In fact, the harder we try to be perfect, the more we increase the probability of certain types of failure. Excessive internal pressure pushes us to chemicals for relaxation; the zeal not to miss a possibility results in exorbitant charges, and so on.

Lawyers, insurers, and the public refuse to accept the inevitability of our frailties. We are exhorted, goaded, expected and even ordered to meet "minimum standards." And if we claim that peak performance at every moment cannot be a "minimum" standard, we are looked at with suspicion. Why are we unwilling to assure all patients such a "simple" thing as this reasonable "minimum" of care? Who can disagree that each patient deserves a caring and competent and attentive physician at all times. But where can we find human beings who can be that way 100% of the time?

Other areas of our culture have zero tolerance for error, like the Defense Department and NASA. Those areas now use duplicate and triplicate systems, with fail-safe overrides. Medical decision-making does not fit that model. The medical culture has reacted to the need for unerring performance by expecting more of the same basic equipment. We merely tighten up our rear ends, and look behind our shoulder all the time.

Constantly on guard against mistakes, we feel surrounded by dangers:

- the danger of errors of omission, forgetting something;
- the danger of errors of commission, doing something incorrectly,
- the danger of careless speech, of admitting error, vulnerability, uncertainty or guilt;
- the danger of attack, by vengeful or crazy patients, predatory lawyers, or merciless automaton bureaucrats;
- the danger of one moment of inattention, that hurts someone, and that eventually wipes out EVERYTHING.

One moment of inattention could destroy our reputation, our livelihood, our social standing and material security, our own sense of competence, our self-worth and "peace of mind." It can invalidate a lifetime of sincere effort and good work.

Society's loss of respect for physicians weighs on us heavily. We feel used as scapegoats for the inescapable raw deals of life--pain, loss and death. Our motives are suspect, with our commitment to money overestimated and our commitment to healing underestimated. Those who feel vulnerable, powerless and dependent on us resent us. Those who think we are rich, arrogant and immune from the inconveniences of everyday life look for opportunities to bring us low.

And here's the sad part: We do not support one another and admit the impossibility of society's expectations. We rail against lawyers, bureaucrats and society, but we do not give comfort and protection to each other. Instead, we keep so busy on the perfection treadmill, that we have no time to spend with those who are in trouble.

Few physicians say they are happy to be in medicine these days. Most seem to be overcommitted and drained of energy. How can we keep our courage up, be proud of our choice of an honorable and fulfilling profession, and find ways to work around our natural inability to be perfect?

In my opinion, the Alaska State Medical Association, and its component local societies have an obvious but neglected role to play in tending to the emotional tension and spiritual near-exhaustion of the state's physicians. The major growth in ASMA in the last few years has been focussed outward--developing ties with the legislature, the bureaucracy, and the public. That work is essential and will continue. But perhaps we need to focus new efforts inward as well. By inward, I mean more than traditional member services like directories, newsletters and informational meetings.

By inward, I mean that ASMA could serve as solace for us, and provide a place and people we can come to for acceptance, help, and a sympathetic ear. Our Impaired Physicians Program has had a good start, but it is aimed at the small group that has become clinically ill. Some other states have formed malpractice support groups, acknowledging that a law suit may be as much or more of a crisis as divorce or death. At least one state society has a group that meets monthly for mutual support at breakfast. The ASMA Council meeting in October will hear more about this new "therapeutic" role for ASMA. The Anchorage Medical Society meeting in February will feature a medical ethicist who will help us talk about our human frailty, and the pressures for perfection. If these beginnings are successful, more events will be planned.

Those of us who are active in organized medicine in Alaska are seeking ways to serve our constituents--Alaskan physicians--better. In order to improve our healing of others, perhaps we can begin by healing ourselves.

Jennifer Christian, M.D.
Municipality of Anchorage
Department of Health and Human Services

Westmark
HOTELS
ALASKA/YUKON

March 14, 1990

Hon. Max F. Gruenberg Jr., Co-Chairman
Hon. Peter Goll, Co-Chairman
House Judiciary Committee
P.O. Box V
Juneau, AK 99811

Dear Co-Chairmen Gruenberg and Goll:

It is with pride that I write on behalf of the some 2,300 people and over 30 organizations who are the Citizens' Coalition for Tort Reform. It was just a few days ago I was chosen, together with Frank Turpin and Dr. David A. McGuire, to be the leadership for the Coalition.

Shortly after its formation in October of 1985, the Coalition took a close look at how the tort reparations system worked. It revealed that it wasn't working. It was inefficient, not cost effective and the bulk of its caseload was not addressed in a timely and fair fashion. The tort reparations system needed a thorough overhaul then and it does today.

Sixteen proposals were set out to address the major faults of the system. Since that time, several significant proposals were put forth by others to deal with other major faults. Only one issue has been clearly deal with, that is, through Ballot Measure No. 2, the voters on November 8, 1988, voted by a margin of 72% to 28% to change the doctrine of joint and several liability to several liability.

HB 166 addresses most of the proposals, but not all. Further, HB 166 contains significant modifications to the original concepts. I submit that the Citizens' Coalition for Tort Reform has already compromised its agenda in order to be fair.

Much of the body of tort law by which issues are now judged has come about through the judicial process. We believe it is time for public debate. We urge movement of HB 166 from your committee to the floor of the House where that debate can occur.

Sincerely,

WESTMARK HOTELS, INC.

Al Parrish
Co-Chairman

880 H Street, Suite 101
Anchorage, Alaska 99501
(907) 272-9403

jcn

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary Committee
committee name

committee on HB 349, HB 350, HB 336 , dated March 15, 1990 .
bill/subject

The Alaska State Medical Association and the Health Association of Alaska with its member hospitals and nursing homes in a news release state that they both OPPOSE this legislation. These two organizations have the most information regarding medical malpractice issues and I feel our State Legislature should take into consideration their combined members knowledge and expertise in this field before considering legislation in this area.
The Federal Government provides the Federal Tort Claims Act which covers physicians practicing in Indian Health Service facilities, Federal Hospitals and federal contractors as well as other providers affiliated with the Federal Government. This makes malpractice insurance unnecessary for physicians and hospitals so affiliated.

Most non federal hospitals require their physicians to maintain medical malpractice insurance as a prerequisite to attaining medical staff privledges. The dis-incentive to practice in Alaska is no greater than to set up a practice anywhere else because of the malpractice costs associated with practicing medicine.

Are any other states subsidizing physician's malpractice insurance costs? This would appear to be a tax on all Alaskans to provide a subsidy for a few of the upper income residents.

Malpractice rates are figured like automobile insurance rates, the more frequent claims are filed, the greater the cost of the insurance. Will this subsidy encourage a high quality supply of physicians? Will this alone increase availability of physicians in Alaska? Or will it tend to attract those relatively few physicians who have numerous malpractice claims against them, thus have high malpractice insurance rates in the states where they are currently residing? By subsidizing a physician with numerous claims in their background, this protects the negligent physician against the economic penalty of their past malpractice involvements. This could result in a lower quality of care being provided for Alaskans than would have occured if some other enticement to practice here had had been used, for example: student loan payback funds for years of service, loan forgiveness, etc.

Signed: Dianne Rabb
Testifier

Norton Sound Health Corp.
Representing (Optional)

Nome Alaska
Address

907 443-33]]
Phone No.

KETCHIKAN MEDICAL CLINIC, INC.
3612 Tongass
Ketchikan, Alaska 99901

H.J. Henrickson, M.D., F.A.A.F.P.
D.E. Johnson, M.D., F.A.A.P.

Phone 225-5144

Hayden

March 16, 1990

The Honorable Peter Goll
Alaska State Legislature
P.O. Box V (MS 3100)
Juneau, Alaska 99811

Dear Representative Goll:

I am writing regarding House Bill 166, heard yesterday in the House Judiciary Committee. I am writing specifically in response to your questions regarding the Statute of Limitations language on pages 3 and 4.

As a pediatrician, I am certainly in support of special measures to protect children. As I said in my testimony, I believe that in Alaska children are safeguarded by a system of public and personal health care that would discover any real problems. Language in other states where this issue has been addressed has often dealt with the person's sixth or eighth birthday, the former being after they are already in one year of school, the second after they have been in three years of school.

Holding a physician responsible for parental actions is a strange way to proceed, and opens the door for all sorts of mischief and cross actions between parents and children. I am not sure that that is what is intended, but I see it as a likely outcome if you pass the language in lines 6-7 on page 4. I cannot see that you would harm the intent of that protection for children by simply deleting the words "a parent, guardian," and simply substitute "an" so that it would read, "fraud or collusion by an insurer or physician, resulting in failure".

Hayden note

You mentioned the fact that chiropractors can now do school entrance physical examinations. I would hasten to remind you that that change was not supported by the medical association, and was enacted by the legislature against the advice of both the physicians and the Department of Health and Social Services.

and over my dead

Thank you for scheduling more hearings on House Bill 166 in the House Judiciary Committee. I am hopeful that you will complete your committee deliberations promptly, and send this measure to the House for deliberations by the full body

If there is other information or other opinion that I could provide, please do not hesitate to contact me. I will be following the deliberations of your committee with considerable interest.

Yours truly,

David E. Johnson, M.D.

DEJ:bjh

Alaska State Legislature

Please enter into the record my testimony to the Labor + Commerce committee name

committee on HB 166 / Tort Reform bill/subject dated 3/15/90

Chairman + Committee members:

I would like to support HB 166 and its moving from Committee to the floor for general debate. The provision of this bill help address several issues which would contribute to reducing the litigious climate which affects the conduct of business, the provision of health care, and the operation of non-profit organizations. It is in changing this climate that the legislature can provide leadership, and we can be less at the mercy of narrowly derived case law, in managing the legal environment of our state.

Provisions to reduce frivolous but expensive litigation, may to some extent reduce insurance costs for all, but more important will reduce the costs of health care as it has evolved in this litigious climate. Much time, effort and expense is currently devoted by hospitals, hospital medical staffs and individual physicians to the practice of "defensible" medicine. This bears little resemblance to high quality, innovative or human practice of medicine or provision of health care. It is not an "us versus them" issue, nor one of physicians economics. Support of this bill will contribute to, as one small step, an improvement in the legal environment which has adversely affected us all.

Signed: _____
Testifier

Scott Emery SCOTT EMERY MD.

Representing (Optional)
President, Medical Staff, Fairbanks Memorial Hosp.

Address
1650 Cowles St. Fairbanks, AK 99701

Phone No. 452-1739

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary committee name

committee on HB 336 bill/subject, dated 3/15/90.

I am opposed to HB 336. Expanding the Medical advisory panel to include 3 lay people (who would then constitute a majority) would totally undermine the credibility & effectiveness of what is supposed to be an expert panel on medical complaints & conduct.

Signed: _____

Testifier Lenore F. Goldberg (Mrs.)

Representing (Optional) 1705 Celtic St.

Address Fbks, Ak. 99701

Phone No. 457-6502

9/86 Legislative Information Office

(over)

Alaska State Legislature

Please enter into the record my testimony on the House Judiciary
committee name

committee on HB-166 Tort Reform, dated 3-15-90
bill/subject

I encourage the Interior Delegation to Support Bill HB-166 - The high malpractice insurance premiums are discouraging local physicians in continuing their practice in Fbks.

I am asking all the following representatives:

Boyer - Sharp - Kapsner - Davis & Miller to support HB-166.

Thank you very much and I am expecting your efforts.

Signed: Marian E Rundquist
Testifier

Fairbanks Medical Community of 100
Representing (Optional)

1633 Market St Fairbanks 99709
Address

474-0963 - home 452-8181 work
Phone No.

FRANKLIN & ASSOCIATES

Consulting Engineers

1813 East First Avenue
Suite 207
Anchorage, Alaska 99501
(907) 277-1631

March 14, 1990

Rep. Max Gruenberg
Co-Chairman
House Judiciary Committee
Alaska State Legislature
P.O. Box V (MS 3100)
Juneau, Alaska 99811

Dear Representative Gruenberg:

The people of this state left little doubt about their attitude on tort reform when they voted for pure several liability, Ballot Measure No. 2, in the November 1988 General Election. The 70% vote for the issue means nearly three quarters of Alaskans want tort reform.

Representatives Cotten (D), Larson (D), Hoffman (D), Pettyjohn (R), Grussendorf (D), Foster (D), Collins (R), and Roucher (D) are sponsors of HB 166, a comprehensive tort reform bill. They are doing something about an issue which their constituents support strongly.

HB 166 was passed out of the House Labor and Commerce Committee. It is now stuck in the Judiciary Committee. Please pass HB 166 out of the Judiciary Committee without further delay.

Sincerely,

Nelson M. Franklin, P.E.

LEGISLATIVE TELECONFERENCE NETWORK

SIGN-IN SHEET

SPONSOR: HOUSE JUDICIARY

SUBJECT: HB 1616 CIVIL LIABILITY

START, END TIME: 1:15 p. DATE: 3-14-90

PLEASE PRINT

	NAME/REPRESENTING	ADDRESS	PHONE #	TESTIFY	OBSERVE	HB #
1	Debra Gruno/AATL & AAT	540 'L' Street Suite 102	258-4040		X	166
2	DOUG STARK/ANC. CH. of COM.	437 E ST #300	272-2401	X		166
3	GENE ROGUSZKA	4320 O'MALLEY RD 99516	346-1024		X	161
4	[illegible]	3200 Providence Dr, 99519-6604	562-2211	X		166
5	Dan J Morgan	16505 Bruyan AK 99508	277-1522		X	166
6	Mike Schneider	880 N St #202 Anc AK 99501	277-4551			
7	FRANK THOMAS-MDIARS	12541 Atherton 99516	345-7101			166
8	AMY CHAFFIN RN	3200 PROVIDENCE DR 99508	261-3007		✓	
9	Barbara Summers	4900 Eagle St Anchorage	562-2281		✓	
10	Margaret R. Wolfe	Midtown Day Care Center 1677 Juneau Dr 99501	274-8424	X		166
11	[illegible]	[illegible]	[illegible]		X	166
12	Lou Raly RN	3200 Providence Dr	261-3141		X	
13	Linda Hattan	PO Box 14-2694 Anch.	272-3434		X	
14	Shirley Marshall	15711 Stonewood Circle Anch AK 99516	345-7441		X	166
15	Karl Garber	3801 Robin Anch AK 99504	337 2937		X	166
16	Janet Oates	9291 Hiland Rd Eagle River	696-2347		X	
17	Terry Wilie	4210 Raspberry Way 99517	267-7111		X	16
18	MANUEL A. WALKER Tlingit Haida Central Council	12930 Admiralty Pl Anch AK 99515-3224	(W) 265-2416 (H) 345-0363		X	

LEGISLATIVE TELECONFERENCE NETWORK

SIGN-IN SHEET

SPONSOR: House Judiciary

SUBJECT: HB 166: Civil Liability

START/END TIME: 1:15 p DATE: 3-14-90

PLEASE PRINT

	NAME/REPRESENTING	ADDRESS	PHONE #	TESTIFY	OBSERVE	HB #
1	Rep. Mary Hunter/Blue	732 Rockwell Kodiak	262-2515	✓		166
2	Ruth Wirtz	3600 C St #742	561-4777		X	166
3	Mary Pierce/MICA	4000 Old Seward Hwy Suite 205 Anch, AK	563-3474		X	166
4	NELSON M. FRANKLIN	1813 E FIRST # 207 ANCH 99501	277-1631	X		166
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						

Alaska State Legislature

Please enter into the record my testimony to the Judiciary
committee name

committee on HB 166 - . dated 3/14/90
bill/subject

see attached

Signed: Peggy P Harding
Testifier

Representing (Optional)

235 View Ave
Address

452-2967
Phone No.

1

March 14, 1990

Dear Gentlemen:

The more I study the question of tort reform, the more concerned I become.

The first point that disturbs me seems to be that we have blurred the concept of fault. As legal issues become more complex, determining precise fault has become more difficult. Today, the emphasis is being placed on providing the injured party with some sort of redress regardless of blame, especially in the area of non-economic damages. The ability to pay becomes more crucial than who is at fault. We badly need a return to fairness in apportioning the award according to apportionment fault, regardless of the ability to pay. Insurance companies, I believe, justly calculate their projections based on the assumption that claims are legitimate only when their client is at fault. When the courts abandon fault as an element of liability, the concept of insurance becomes one of back-breaking social engineering. It will be interesting to note the effect of the recently passed public initiative on the system.

Much of House Bill 166 seems to concern insurance matters. To my mind, the insurance dilemma is merely a symptom of an underlying deep-seated predicament with its roots in the public's perception of society and how we use the system. Our society is becoming evermore litigious and the courts are overburdened, costs are skyrocketing, and incentives for big bucks for attorneys and successful plaintiffs are fanning the flames at public expense. It is time for the pendulum to swing back lest we ruin the clock.

We have developed the most expensive legal system in the world. Rising compensation awards, contingency fees, and court delays are escalating this expense. While the health care industry, manufacturers, design professionals, state and local governments, and other deep pockets, are the most often saddled with these suits, it must be remembered that these costs are passed on to the consumer and to the tax payer. As Pogo says, "we have met the enemy and he is us".

The effect of this expensive legal system is that so little of the award reaches the plaintiff. I have seen an estimate that $.28 of every dollar of the direct costs goes to the victim. The rest goes to lawyers on both sides. We really do have to do better. No system can survive such overhead. I believe that House Bill 166 addresses this problem and should be supported in its entirety.

One thing that is often forgotten is the cost of the court system itself. One estimate that I have seen, albeit very old, is that in 1982, the Institute for Civil Justice estimated that the public taxpayer funneled $320 million into the court system just to process civil suits related to personal injury, death, and property damage. In addition, one must remember that when the government itself is the defendant, "that a few less cops get hired, a fire engine isn't bought, the pipes leak longer, the streets deteriorate, it all comes out of the same kitty".

Punitive damages, if any, should be paid to the State or Federal Treasury. The prospect of receiving this bonus offers tremendous incentives for lawyers and plaintiffs to sue. (2) Additionally and finally, I am concerned about the concept of non-economic damages. I ask myself if I would accept a large award to be paralyzed for the rest of my life and, honestly, my answer would be, I would rather not. However, when reflecting on this issue, I remember an incident when my property was condemned for a highway. I felt the same way. That is, no amount of money could compensate me for the traffic, the noise, the drunks stopping at my door, my car being hit while parked outside my house, people staring in the windows while waiting for a light, etc. Nor did I receive any. While not an identical situation, I believe that there is a parallel. My conclusion is that there is no reasonable compensation for non-economic damages. And further, I believe, that society as a payor, has an interest in limiting the cost. It certainly limited it in my case.

According to a Gallup poll, the public urgently believes the system needs pruning. It believes the system is too expensive and fraught with too many lawsuits. In addition, the public feels that change is appropriate for containing court costs and more equitably shifting the burden of a lawsuit expense among the parties concerned. The public would like as part of the verdict the courts to apportion court and legal representation costs among the parties based on the actual hours worked, actual hours of court time, and other expenses as accounted for, and to eliminate contingency fees. I would, therefore, ask you to pass House Bill 166 as originally written, and I would further ask you to encourage

people to settle their differences outside of court by providing for mandatory and binding arbitration of small claim, eliminating punitive damages as an incentive, limiting the awards for non-economic damages, and limiting contingency fees. I would further ask you to allow for a rational verdict by considering alternate sources of reimbursement in order to avoid duplication (as is included in House Bill 166), eliminate ad damnum clauses and apportion liability taking into account the extent that the plaintiff is responsible for any injuries or damages to himself. To my mind, all of these provisions are necessary and none should be ignored.

Sincerely yours,

Roger F. Harding, M.D.

RFH:ms

Alaska State Legislature

Please enter into the record my testimony to the Judiciary Committee
committee name

committee on HB 166 . dated 3/14/90 .
bill/subject

I have been a physician in Fairbanks for 10 years. I am convinced Tort Reform really is needed in Alaska because of experience in other States where meanful tort reform has occured. An example is my malpractice insurance. I've never had a claim. Yet, since 1985 my insurance premium has increased by 553%. (from $748/year in 1985 to $15,196/year in 1991) In 1989 my premium increased by 11% while doctors insured by this same company in California received a 5% rebate. The difference is attributed wholly to Tort Reform that has occured in California.

Last year 70% of Alaskan voters supported tort reform. I urge you to act on this mandate and pass HB 166

Signed: Richard J Burger M.D.
Testifier

Self
Representing (Optional)

2009 Cowles St, Fairbanks AK 99701
Address

907-452-6610
Phone No.

Alaska State Legislature

Please enter into the record my testimony to the House Judiciary
committee name

committee on House - 166 , dated 3/14/97 .
bill/subject

see attached

Signed: Mary-Wing MD
Testifier

Representing (Optional)

8 Bonnie Ave, Hbks AK 99701
Address

456-5711
Phone No.

9/96 Legislative Information Office

7

Terry Martin

Mary C. Wing, M.D.
LEMETA MEDICAL CLINIC, INC.
#8 BONNIE STREET
FAIRBANKS, ALASKA 99701
TELEPHONE (907) 456-6711

TESTIMONY FOR HOUSE BILL 166
3-14-90

The cost of medical liability insurance is causing a crisis in health care in America. In the last 3 - 4 years, one third of the Family Practice and Obstetric physicians have quit doing obstetrics. Currently MICA rates are $89,000 year. When doctors stop delivering babies, they must then purchase a tail policy that covers future lawsuits for past events. That policy costs 3 times the last year's rate. That is $267,000 at current rates in Alaska. That's why doctors are quitting delivers or retiring early. Unless doctors add $1000 - 4000 to the cost of each delivery (depending on the Number done each year), they can not recover the expense. They are forced to raise rates uniformily or stop delivering babies. Two local Family Practice physicians raised their rates 40% in order to continue obstetrics. These events are occurring in other specialties thereby limiting services to the public.

People who have been injured deserve compensation but there is not enough money in the world to pay everyone what they feel they deserve. We need a mechanism to make awards more uniform and fair, and we need restrictions on awards so we don't bankrupt the system or drive the cost of medical care beyound the price of the average family.

House bill 166 does not limit the ability to sue. 70% of your fellow Alaskans voted for the tort reform referendum. I ask your support for this bill.

Mary C. Wing, M.D.
LEMKTA MEDICAL CLINIC, INC.
88 BONNIE STREET
FAIRBANKS, ALASKA 99701
TELEPHONE (907) 456-5711

TESTIMONY FOR HOUSE BILL 166
3-14-90

The cost of medical liability insurance is causing a crisis in health care in America. In the last 3 - 4 years, one third of the Family Practice and Obstetric physicians have quit doing obstetrics. Currently MICA rates are $89,000 year. When doctors stop delivering babies, they must then purchase a tail policy that covers future lawsuits for past events. That policy costs 3 times the last year's rate. That is $267,000 at current rates in Alaska. That's why doctors are quitting delivers or retiring early. Unless doctors add $1000 - 4000 to the cost of each delivery (depending on the Number done each year), they can not recover the expense. They are forced to raise rates uniformily or stop delivering babies. Two local Family Practice physicians raised their rates 40% in order to continue obstetrics. These events are occurring in other specialties thereby limiting services to the public.

People who have been injured deserve compensation but there is not enough money in the world to pay everyone what they feel they deserve. We need a mechanism to make awards more uniform and fair, and we need restrictions on awards so we don't bankrupt the system or drive the cost of medical care beyound the price of the average family.

House bill 166 does not limit the ability to sue. 70% of your fellow Alaskans voted for the tort reform referendum. I ask your support for this bill.

Mary C. Wing

10

Johnny Ellis

Mary C. Wing, M.D.
LEMETA MEDICAL CLINIC, INC.
#6 BONNIE STREET
FAIRBANKS, ALASKA 99701
TELEPHONE (907) 456-5711

TESTIMONY FOR HOUSE BILL 166
3-14-90

The cost of medical liability insurance is causing a crisis in health care in America. In the last 3 - 4 years, one third of the Family Practice and Obstetric physicians have quit doing obstetrics. Currently MICA rates are $89,000 year. When doctors stop delivering babies, they must then purchase a tail policy that covers future lawsuits for past events. That policy costs 3 times the last year's rate. That is $267,000 at current rates in Alaska. That's why doctors are quitting delivers or retiring early. Unless doctors add $1000 - 4000 to the cost of each delivery (depending on the Number done each year), they can not recover the expense. They are forced to raise rates uniformily or stop delivering babies. Two local Family Practice physicians raised their rates 40% in order to continue obstetrics. These events are occurring in other specialties thereby limiting services to the public.

People who have been injured deserve compensation but there is not enough money in the world to pay everyone what they feel they deserve. We need a mechanism to make awards more uniform and fair, and we need restrictions on awards so we don't bankrupt the system or drive the cost of medical care beyound the price or the average family.

House bill 166 does not limit the ability to sue. 70% of your fellow Alaskans voted for the tort reform referendum. I ask your support for this bill.

Mary C Wing

Cliff Davis

Mary C. Wing, M.D.
LEMETA MEDICAL CLINIC, INC.
#8 BONNIE STREET
FAIRBANKS, ALASKA 99701
TELEPHONE (907) 456-5711

TESTIMONY FOR HOUSE BILL 166
3-14-90

The cost of medical liability insurance is causing a crisis in health care in America. In the last 3 - 4 years, one third of the Family Practice and Obstetric physicians have quit doing obstetrics. Currently MICA rates are $89,000 year. When doctors stop delivering babies, they must then purchase a tail policy that covers future lawsuits for past events. That policy costs 3 times the last year's rate. That is $267,000 at current rates in Alaska. That's why doctors are quitting delivers or retiring early. Unless doctors add $1000 - 4000 to the cost of each delivery (depending on the Number done each year), they can not recover the expense. They are forced to raise rates uniformily or stop delivering babies. Two local Family Practice physicians raised their rates 40% in order to continue obstetrics. These events are occurring in other specialties thereby limiting services to the public.

People who have been injured deserve compensation but there is not enough money in the world to pay everyone what they feel they deserve. We need a mechanism to make awards more uniform and fair, and we need restrictions on awards so we don't bankrupt the system or drive the cost of medical care beyound the price of the average family.

House bill 166 does not limit the abiliy to sue. 70% of your fellow Alaskans voted for the tort reform referendum. I ask your support for this bill.

Mary C Wing

Mike Miller

Mary C. Wing, M.D.
LEMETA MEDICAL CLINIC, INC.
#8 BONNIE STREET
FAIRBANKS, ALASKA 99701
TELEPHONE (907) 456-8711

TESTIMONY FOR HOUSE BILL 166
3-14-90

The cost of medical liability insurance is causing a crisis in health care in America. In the last 3 - 4 years, one third of the Family Practice and Obstetric physicians have quit doing obstetrics. Currently MICA rates are $89,000 year. When doctors stop delivering babies, they must then purchase a tail policy that covers future lawsuits for past events. That policy costs 3 times the last year's rate. That is $267,000 at current rates in Alaska. That's why doctors are quitting delivers or retiring early. Unless doctors add $1000 - 4000 to the cost of each delivery (depending on the Number done each year), they can not recover the expense. They are forced to raise rates uniformily or stop delivering babies. Two local Family Practice physicians raised their rates 40% in order to continue obstetrics. These events are occurring in other specialties thereby limiting services to the public.

People who have been injured deserve compensation but there is not enough money in the world to pay everyone what they feel they deserve. We need a mechanism to make awards more uniform and fair, and we need restrictions on awards so we don't bankrupt the system or drive the cost of medical care beyound the price of the average family.

House bill 166 does not limit the ability to sue. 70% of your fellow Alaskans voted for the tort reform referendum. I ask your support for this bill.

Mary Wing

Mike Davis

Mary C. Wing, M.D.
LEMETA MEDICAL CLINIC, INC.
#6 BONNIE STREET
FAIRBANKS, ALASKA 99701
TELEPHONE (907) 456-6711

TESTIMONY FOR HOUSE BILL 166
3-14-90

The cost of medical liability insurance is causing a crisis in health care in America. In the last 3 - 4 years, one third of the Family Practice and Obstetric physicians have quit doing obstetrics. Currently MICA rates are $89,000 year. When doctors stop delivering babies, they must then purchase a tail policy that covers future lawsuits for past events. That policy costs 3 times the last year's rate. That is $267,000 at current rates in Alaska. That's why doctors are quitting delivers or retiring early. Unless doctors add $1000 - 4000 to the cost of each delivery (depending on the Number done each year), they can not recover the expense. They are forced to raise rates uniformily or stop delivering babies. Two local Family Practice physicians raised their rates 40% in order to continue obstetrics. These events are occurring in other specialties thereby limiting services to the public.

People who have been injured deserve compensation but there is not enough money in the world to pay everyone what they feel they deserve. We need a mechanism to make awards more uniform and fair, and we need restrictions on awards so we don't bankrupt the system or drive the cost of medical care beyound the price of the average family.

House bill 166 does not limit the ability to sue. 70% of your fellow Alaskans voted for the tort reform referendum. I ask your support for this bill.

Mary Wing

12

HB

174

HOUSE COMMITTEE REPORT

(7)
Date Referred: April 5, 1989 FURTHER REFERRALS:

Date of Committee Action: 4/28/89

The JUDICIARY Committee considered: HB 174

HOUSE BILL NO. 174 [MUNICIPAL REFERENDUM]
"An Act relating to suspension of a municipal ordinance or resolution against which a referendum petition is filed."

RECOMMENDATIONS:
[ ] be replaced with ______ [ ] the same title [ ] a new title
[ ] have attached amendment(s)
[ ] do pass
[ ] do not pass
[ ] no recommendation
[✓] individual recommendations
[ ] additional referral to the ______ Committee

ADOPTS: ______ letter of intent

ATTACHES NEW FISCAL NOTE(s): (Dept)
[ ] fiscal impact ______
[ ] zero fiscal note ______
[ ] zero with analysis ______

APPROVES PREVIOUS: (Date/Dept)
[ ] fiscal note(s) ______
[x] zero fiscal note(s) CAndRA 4/5/89
[ ] zero fn/analysis ______

SIGNING DO PASS:
Mike Miller

SIGNING: (Check approp. column)

	Do Not Pass	No Rec	Amend
[signature]		✓	
[signature]		✓	
Mike Davis		✓	
[signature]		✓	
[signature]		✓	
[signature]		✓	

[signature] / [signature]
Chairman's Signature

HOUSE COMMITTEE REPORT

4/5

(5)
Date Referred: February 15, 1989 FURTHER REFERRALS: JUDICIARY

Date of Committee Action: 4/4/89

The COMMUNITY & REGIONAL AFFAIRS Committee considered: HB 174

HOUSE BILL NO. 174 [MUNICIPAL REFERENDUM]
"An Act relating to suspension of a municipal ordinance or resolution against which a referendum petition is filed."

RECOMMENDS:

[ ] replacing with _____ [ ] the same title [ ] a new title
[ ] the attached amendment(s)
[ ] do pass
[ ] do not pass
[ ] no recommendation
[✓] individual recommendations
[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of intent

ATTACHES NEW FISCAL NOTE(s):
[ ] fiscal impact
[✓] zero fiscal note CTRA
[ ] zero with analysis

APPROVES PREVIOUS:
[ ] fiscal note(s) published:
_____
[ ] zero fiscal notes(s) published:
_____

SIGNING DO PASS:

Richard Foster FOSTER
Eileen P MacLean MACLEAN

SIGNING OTHER THAN DO PASS:
(Do Not Pass, No Recommendation, Amend)

Cheri Davis No Rec C. DAVIS
no rec PETTYJOH.

Eileen P. MacLean
Chairman's signature

STATE OF ALASKA
1989 LEGISLATIVE SESSION

BILL VERSION: HB 174
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: "An Act..suspension of a municipal ordinance.."
Sponsor: House C&RA Committee
Requestor: _____

Agency Affected: Community & Regional Affairs
BRU: _____
Components: _____

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 89	FY 90	FY 91	FY 92	FY 93	FY 94
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-
CAPITAL						
REVENUE						

FUNDING: (Thousands of Dollars)

GENERAL FUND	-0-	-0-	-0-	-0-	-0-	-0-
FEDERAL FUNDS						
OTHER						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:

FULL-TIME	-0-	-0-	-0-	-0-	-0-	-0-
PART-TIME						
TEMPORARY						

ANALYSIS: (Attach a separate page if necessary)

Prepared by: Jim Plasman, Deputy Director
Phone: 465-4750
Division: Municipal & Regional Assistance
Date: April 3, 1989

Approved by Commissioner: David C. Hoffman
Date: 4-3-89
Agency: Community & Regional Affairs

Distribution (by preparer):
Legislative Finance
Legislative Sponsor
Requestor
Office of Management and Budget
Impacted Agency(ies)

Alaska State Legislature

HOUSE OF REPRESENTATIVES

Official Business

P.O. Box V
State Capitol
Juneau, Alaska 99811

MEMORANDUM

TO: ALL MEMBERS
HOUSE COMMUNITY AND REGIONAL AFFAIRS COMMITTEE

FROM: REPRESENTATIVE EILEEN P. MACLEAN, CHAIRMAN Eileen P. MacLean
HOUSE COMMUNITY AND REGIONAL AFFAIRS COMMITTEE

DATE: February 13, 1989

RE: Proposed Committee Legislation

Please review the enclosed legislation and information pertaining to it. I plan to introduce this legislation on Wednesday, February 15th as a committee bill unless there is objection from members on the committee. The legislation would clarify in statute that an ordinance or resolution is suspended if a referendum petition is filed before the operative date of the ordinance or resolution.

cc: Representative Peter Goll, Co-Chair
Representative Max Gruenberg, Co-Chair
House Judiciary Committee

STATE OF ALASKA
THE LEGISLATURE

POUCH V STATE CAPITOL
JUNEAU ALASKA 99811
907 465 3800

LEGISLATIVE AFFAIRS AGENCY

MEMORANDUM February 1, 1989

SUBJECT: Municipal Referendums
(Work Order No. 16-0722A)

TO: Representative Eileen MacLean, Chairman
Community and Regional Affairs Committee

FROM: Tamara Brandt Cook TBC
Director
Division of Legal Services

You have asked for a draft bill that incorporates the substance of the decision, Interior Taxpayers Association, Inc. v. Fairbanks North Star Borough, 742 P.2d 781 (Alaska 1987). A copy of that case is enclosed for your reference. That case held, in essence, that even when a referendum petition is filed against an ordinance that has already gone into legal effect, that ordinance is suspended if it has not yet become operative. At issue was a sales tax which had been enacted, but collection of the tax had not yet begun at the time the referendum petition was filed.

Existing law now provides for suspension when a petition is filed before the effective date. This draft expands that section to provide for suspension of ordinances or resolutions to when a petition is filed before the operative date of the ordinance or resolution. Please contact me if you would like any changes.

TBC:gc
W6/071

Enclosure(2)

AS 29.26.180(b) THE EFFECTIVE DATE OF THE SUSPENSION OF AN ORDINANCE BEING REFERRED IS EXAMINED.

The Supreme Court of Alaska held that "effective date of the matter referred" refers to the date when the ordinance becomes operative rather than the date when the ordinance becomes law; the law requires that when a petition for a referendum is filed, the ordinance that is the subject of the referral is suspended pending the referendum vote if the "petition is certified before the effective date of the matter referred". The court noted that the term "effective date of the matter referred" can reasonably have at least two meanings: either when the ordinance becomes law or when the ordinance becomes operative. The ordinance in question had become law but did not yet require the collection of the new sales tax. The court noted that under the procedure of the borough, an ordinance takes effect as an ordinance on the first business day after it is adopted; the automatic suspension procedure would be completely meaningless unless the effective date is interpreted to mean when the ordinance becomes operative. The court also agreed that the term "matter referred" is vague." Interior Taxpayers Ass'n. Inc. v. Fairbanks North Star Borough, 742 P.2d 781.

While the decision of the court clarifies the vague phrase, review is recommended.