ALASKA LEGISLATURE COMMITTEE FILES, 1989-1990 8672
5902 HOUSE LABOR & COMMERCE

306

other industries, such as the banking, transportation, and utility industries. At that time, we pointed out that over the last few years rates of return earned by the property/casualty industry have been substantially lower than those earned by comparable industries.

Looking at attachment I, you can see that the property/casualty industry is subject to profitability cycles. Column 1, "underwriting gains/losses" demonstrates the most recent cycle. This underwriting cycle peaked in 1978. Since then it has declined until it bottomed out in 1985 when the industry experienced record underwriting losses. Because of the industry's cyclical nature, we believe that data covering an entire cycle gives a better picture of the industry's profitability.

Since our July testimony, the Insurance Information Institute has reported that the property/casualty industry's earnings improved substantially in 1986. On the basis of its data, we calculate that the industry's after-tax net gain increased from $9.7 billion in 1985 to about $19 billion in 1986. undiscounted

We turn now to our analysis of the profitability of the medical malpractice and general liability lines, two lines that over the past few years have been in the news due to consumers'

difficulties in obtaining coverage at prices they could afford. As we testified last July, and as shown in attachment II, these two lines represent about 8 percent of the property/casualty industry's business but have accounted for over a quarter of the industry's underwriting losses. It should be noted that these losses did not reflect the investment gains applicable to these lines.

PROFITABILITY OF SPECIFIC LINES

To analyze the profitability of the medical malpractice and general liability insurance lines, we used publicly available data reported by the A.M. Best Company in its Casualty Loss Reserve Development on premiums, losses, and expenses. We used Best's data because it is the only aggregated data base readily available to perform such an analysis. Best gathers its data from the annual financial statements the insurance companies file with state regulators. We did not test the accuracy or adequacy of the data reported by the companies or by Best.

Because Best does not allocate all investment income and gains by insurance line, we had to estimate the investment results for these lines. Our estimates were derived by calculating net cash flow after federal income taxes and by assuming that the results had been invested in a representative investment vehicle, 10-year Treasury securities. Treasury

securities were selected because they are virtually risk free, and because claims in the medical malpractice and general liability lines are not settled, in many cases, for 10 years or longer after the premiums are written.

The data reported by Best do not cover the entire industry. Among those not included in the Best data are (1) joint underwriting associations, (2) a small portion of physician-owned insurance companies, (3) reinsurers, (4) small commercial insurers, and (5) self-insurance mechanisms.

We should also note that medical malpractice insurers are not a homogeneous group. Medical malpractice insurance providers are comprised of both stock and mutual insurance companies. Among the mutual insurers are insurance companies formed by medical professionals to assure the availability of medical malpractice insurance at the lowest possible cost. Thus, their motivation is not necessarily profit oriented. The physician-owned and hospital-owned companies included in our analysis comprised approximately 38 percent of our data base. However, to determine the profitability of the medical malpractice insurance line both stock and mutual insurers have been included.

Our analysis of the profitability of the medical malpractice and general liability insurance lines depends primarily on the manner in which reserves for future payment of claims are

established by the industry. These reserves, which are an operating expense are actuarial estimates of claims that are expected to be paid out in the future. Furthermore, these reserves are adjusted periodically to reflect revisions to prior claim and loss expense estimates. Thus, depending on the ultimate loss experience, profitability may be understated or overstated in any given year.

Additionally important is that for legitimate solvency considerations state regulations require that reserves be generally booked at the full value of expected future loss payouts. We have recommended in the past that for tax purposes reserves be set aside on a "discounted" basis because, in reality, this amount invested at interest will be sufficient to meet expected future losses as long as expectations do not substantially change. In its consideration of the Tax Reform Act of 1986, the Congress agreed with our recommendation and required insurers to discount their reserves for tax purposes.

In this testimony, we present four different estimates of medical malpractice and general liability profitability. The first set of estimates assumes that the industry's reserves are adequate to meet expected claims. The second also assumes that the reserves are adequate, but it discounts the reserves. The third estimate assumes the industry has underreserved by 10 and 20 percent. The fourth estimate discounts the reserves derived

in the third estimate. We will first present our estimates for the medical malpractice line, which we show in attachment III, and then our estimates for general liability, which we present in attachment IV.

Profitability when reserves
are not discounted

We initially computed the annual earnings using reserves that had not been discounted. In the case of the medical malpractice line, as you see in attachment III in column 1, we computed a cumulative $653 million loss over the 11-year period 1975 through 1985, with a cumulative rate of return, expressed as a percent of premiums earned, of a negative 4.6 percent.

Profitability improves when
reserves are discounted

However, this estimate does not in our view present a completely accurate picture. Both the medical malpractice and general liability lines are typical of insurance lines in which claims are commonly paid many years after the reserves for those claims have been established. In order to compute such a line's profitability, the established reserves need to be discounted to recognize the time value of money. For example, if a claim will cost $100 in 10 years, should a $100 reserve be immediately

established for that claim or should a reserve of a lesser amount--a discounted amount--be established that, when invested over the 10-year period, will yield $100? If a discounted reserve is established, then a greater amount of that year's annual cash flow will be credited to the line's earnings. Thus, discounting the reserves increases current earnings.

We discounted the reserves by the average annual interest rate earned on 10-year Treasury securities. As you can see in attachment III in column 2, if the reserves are discounted in this manner, the medical malpractice line yielded a profit of $2.2 billion over the 11-year period 1975 through 1985. As a percentage of premiums earned, the medical malpractice line's cumulative rate of return increases from a negative 4.6 percent to a positive 15.3 percent when the reserves are discounted in this manner.

Profitability deteriorates if the reserves established are not adequate to cover claims

In deriving the profitability estimates we have just presented, we assumed that industry-established reserves are sufficient to settle future claims. We made this assumption because companies review their reserve estimates at least annually and are bound by state regulators to provide for fully adequate reserves. Future events, however, may show that the

reserves were either excessive or inadequate. Some in the industry believe that the reserves are inadequate. If, due to unforeseen circumstances, the reserves proved insufficient, then the profitability of the lines would deteriorate. To provide an appropriate degree of conservatism in light of this possibility, we are supplying calculations of profitability on the alternative assumptions that the estimated reserve requirements are inadequate to the extent of 10 percent or 20 percent of their current stated value.

If the reserves needed to be increased by 10 percent, the medical malpractice line's profitability based upon undiscounted reserves for the 11-year period 1975 through 1985 would decline from a $653 million loss to a $1.2 billion loss. Its rate of return as a percentage of premiums earned would decline from a negative 4.6 percent to a negative 8.8 percent.

If the undiscounted reserves proved to be 20-percent deficient, the profitability and rate of return on the medical malpractice line would decline from a $653 million loss to a negative $1.8 billion loss and from a negative 4.6 percent rate of return to a negative 13.0 percent.

Similarly, if the reserves proved to be 10-percent deficient then the medical malpractice line's profitability and rate of return on a discounted basis would decline from a $2.2 billion

profit to a $1.9 billion profit and from a 15.3 percent rate of return to a 13.1 percent rate of return. If the reserves needed boosting by 20 percent to be sufficient, the profitability and rate of return on the medical malpractice line on a discounted basis would decline further to a $1.6 billion profit and a 10.9 percent return.

Profitability of the
general liability line

In attachment IV we show our profitability estimates for the general liability insurance line, which we calculated by using the same methodology as for the medical malpractice line. As column 1 shows, if reserves are not discounted, the general liability line yielded a profit of $2.0 billion for the period 1975 through 1985, with a cumulative rate of return of 3.4 percent. As column 2 shows, with reserve discounting the general liability line yielded a profit of $8.0 billion over the same period, with a cumulative rate of return of 13.4 per cent.

If we assume that reserves were insufficient and needed to be increased by 10 percent, the general liability line's profit based upon undiscounted reserves would decline from $2.0 billion to $783 million, and the rate of return would decline from 3.4 percent to 1.3 percent. If undiscounted reserves were 20-percent

deficient, the general liability line's profitability would decline from $2.0 billion to a negative $462 million, with the rate of return decreasing from a positive 3.4 percent to a negative 0.8 percent.

If we base our estimates on discounted reserves and assume a 10 percent reserve deficiency, then the profitability of the general liability line would be $7.4 billion, as opposed to $8.0 billion on a discounted basis with no deficiency assumed and a rate of return of 12.3 percent as opposed to 13.4 percent. If we assume a 20-percent deficiency, the general liability line on a discounted basis shows a $6.7 billion profit and a rate of return of 11.2 percent.

CONCLUSIONS

Although cyclical in nature, the property/casualty industry, as a whole, has been profitable over the 10-year period 1976 through 1985. Despite faring poorly in recent years, the industry's profitability in terms of its rate of return on net worth over this 10-year period was comparable to that of other industries, such as the banking, transportation, and utility industries. Data for 1986 shows that the underwriting cycle has turned and is now moving in a positive direction.

The profitability of the medical malpractice and general liability lines depends primarily on the manner in which reserves for future payments of claims are established--the adequacy of the reserves and whether those reserves are discounted to reflect their present values. If the reserves established to cover future loss payouts are inadequate, boosting the reserve to cover those losses will decrease the profitability of the line. Conversely, the profitability of the line improves if the reserves are discounted. We have recommended in the past, and the Congress has agreed, that for tax purposes reserves should be established on a discounted basis.

Using reserve amounts as established by the industry and applying different assumptions about reserve adequacies and discounting, we developed four profitability estimates for each line. Essentially, those estimates show that the medical malpractice line incurred losses when the reserves were valued at their full estimated payout, but the line was profitable when the reserves were discounted to present values. On the other hand, the general liability line was profitable under all but one of our estimating assumptions. In that estimate we assumed that the reserves were not discounted to present values and that they were 20-percent deficient.

This concludes my prepared statement. We would be pleased to respond to any questions.

ATTACHMENT I

Combined After-Tax Gains for the Property/Casualty Insurance Industry by Year for the Period 1976-1985 (Consolidated Basis)[a]
($ in millions)

Year	Underwriting gains/losses[b]	Investment gains/losses[c]	Pre-tax total	Federal income tax[d]	After-tax total
1976	($1,726)	$7,173	$5,447	$148	$5,299
1977	1,926	5,063	6,989	1,015	5,974
1978	2,548	7,758	10,306	1,389	8,917
1979	24	11,610	11,634	896	10,738
1980	(1,712)	15,870	14,158	593	13,565
1981	(4,464)	10,858	6,394	55	6,339
1982	(8,303)	18,387	10,084	(716)	10,800
1983	(11,088)	19,441	8,353	(1,218)	9,571
1984	(19,379)	17,875	(1,504)	(1,732)	228
1985	(22,597)	30,219	7,622	(2,030)	9,652
1976-1985	**($64,771)**	**$144,254**	**$79,483**	**($1,600)**	**$81,083**

[a] Consolidated totals eliminate "double counting" by excluding intercompany transactions between parent and subsidiary companies.

[b] Net premiums earned, less losses and expenses.

[c] Net investment income, plus realized and unrealized capital gains.

[d] Negative federal income tax occurs because companies report losses for tax purposes and consequently generate negative income taxes. Negative income taxes can be applied to past taxes paid, and they generate refunds or are carried forward to apply against future tax liabilities.

Source: Data used in the preparation of this table obtained from A.M. Best Company publications.

ATTACHMENT II

Net Premiums Earned, Underwriting Gains/Losses, and Combined Ratios by Insurance Line for the Period 1976-1985
($ in millions)

Insurance lines	Net premiums earned	Premiums as a percent of all lines	Underwriting gains/losses[a]	Underwriting gains/losses as a percent of all lines	Combined ratios
Auto liability (Private passenger)	$192,432	20.49	($16,509)	25.49	107.9
Auto physical damage (Private passenger)	134,515	14.32	815	(1.26)	98.6
Workers' compensation	128,099	13.64	(1,589)	2.45	100.9
Homeowners multiple peril	96,376	10.26	(3,813)	5.89	102.4
Commercial multiple peril	66,002	7.03	(7,014)	10.83	108.5
General liability	**61,746**	**6.57**	**(13,255)**	**20.46**	**120.0**
Auto liability (Commercial)	46,150	4.91	(8,746)	13.50	117.6
Auto physical damage (Commercial)	25,599	2.73	(94)	0.15	99.1
Medical malpractice	**14,143**	**1.51**	**(5,177)**	**7.99**	**135.7**
All other lines	174,066	18.54	(9,389)	14.50	--[b]
Total - all lines	$939,128	100.00%	($64,771)	100.00%	105.9

[a]Net premiums earned, less losses and expenses. This column does not include investment gains allocated by insurance line.

[b]All other lines includes: reinsurance (114.9); fire (96.9); inland marine (98.0); group accident and health (111.7); allied lines (97.1); burglary and theft (81.2); surety (95.7); ocean marine (108.0); other accident and health (101.8); farmowners multiple peril (109.5); fidelity (104.8); boiler and machinery (93.8); aircraft (104.1); and miscellaneous (111.0).

Source: Data used in the preparation of this table obtained from A.M. Best Company publications.

ATTACHMENT III

Summary of Profitability of the Medical Malpractice Insurance Line, 1975-1985[a]
($ in millions)

Using company-established reserves:

	Not discounted by GAO	Discounted by GAO
Net premiums earned	$14,187	$14,187
Interest earned (estimated)	4,352	4,352
Revenues	18,539	18,539
Payments & expenses	8,772	8,772
Reserves	10,976[b]	8,152
Taxes	(556)	(556)
Expenses	19,192	16,368
Earnings	($ 653)	$ 2,171

	Not discounted by GAO		Discounted by GAO	
Reserves	Earnings	Percent rate of return[c]	Earnings	Percent rate of return[c]
Adequate	**($ 653)**	**(4.6)**	**$2,171**	**15.3**
10% inadequate	**(1,245)**	**(8.8)**	**1,861**	**13.1**
20% inadequate	**(1,838)**	**(13.0)**	**1,551**	**10.9**

[a]Medical malpractice profitability, as shown above, depends on (1) the adequacy of reserves established to settle claims, and (2) the degree to which the reserves are discounted. This table shows the level of profitability assuming three levels of reserve adequacy, not discounted and discounted.

[b]Of this $10,976 million reserve $2,660 million is shown in the statements of the Physician Insurers Association of America as already having been discounted. The reserve shown in the second column is the result of discounting the remaining $8,316 million and adding the result to the $2,660 million already discounted by the companies.

[c]Rate of return as percent of net premiums earned.

Source: Data used in the preparation of this table obtained from A.M. Best Company publications and the Physician Insurers Association of America.

ATTACHMENT IV

Summary of Profitability of the General Liability Insurance Line, 1975-1985[a]
($ in millions)

Using company-established reserves:

	Not discounted by GAO	Discounted by GAO
Net premiums earned	$59,812	$59,812
Interest earned (estimated)	12,234	12,234
Revenues	72,046	72,046
Payments & expenses	45,235	45,235
Reserves	23,056	17,069
Taxes	1,726	1,726
Expenses	70,017	64,030
Earnings[b]	$ 2,028	$ 8,014

	Not discounted by GAO		Discounted by GAO	
Reserves	Earnings	Percent rate of return[c]	Earnings	Percent rate of return[c]
Adequate	$2,028	3.4	$ 8,014	13.4
10% inadequate	783	1.3	7,368	12.3
20% inadequate	(462)	(0.8)	6,721	11.2

[a]General liability profitability, as shown above, depends on (1) the adequacy of reserves established to settle claims, and (2) the degree to which the reserves are discounted. This data shows the level of profitability assuming various levels of reserve adequacy and discounting.

[b]Does not add due to rounding.

[c]Rate of return as percent of net premiums earned.

Source: Data used in the preparation of this table obtained from A.M. Best Company publications.

Bill - HB168
I hope this helps.
AJA
Statute of Repose

MILTON F. LUNCH, ESQUIRE
A/E LIABILITY CONSULTANT
TWO WISCONSIN CIRCLE
CHEVY CHASE, MARYLAND 20815-7003

301-951-9876

March 9, 1989

Mr. Michael F. Davy, P.E.
Davy Engineering Co.
P.O. Box 2076
La Crosse, Wi. 54602-2076

ALASKA CHAPTER
THE AMERICAN INSTITUTE OF ARCHITECTS
P.O. BOX 10-3563 • ANCHORAGE, ALASKA 99510-3563

Dear Mike:

Upon my return from the Park City meeting I found the decision of the Wisconsin Supreme Court in Funk v. Wollin Silo & Equipment, Inc., courtesy of Brian Mullins. I have since received several additional copies from others and particularly the draft legislation from Judith A. Whalen and Robert Brandenburg, respectively. I understand this draft legislation was prepared before the Supreme Court decision was handed down, and hence presumably does not reflect the impact of that decision.

Now, as to the draft legislation itself, it is a good idea to include a detailed statement of legislative intent and justification for a new statute. That technique worked in Florida, where the original statute had been rejected twice, and upheld on the third try largely on the basis of the legislative findings. In that decision the Florida Court of Appeals pointedly said, after noting the detailed legislative findings justifying the statute:

> "The legislature has the last word on declaration of public policy. The courts are bound to give great weight to legislative determinations of fact. It is not unusual for a subsequent legislative determination of the legality of purpose to be served by an undertaking to be deemed sufficient to overcome a prior judicial decision to the contrary." (American Liberty Insurance Co. v. West & Convers, Architects and Engineers, Inc., 491 So. 2d 573 (Fla. App. 2 Dist. 1986)

We can only hope that the Wisconsin Supreme Court will heed those words of wisdom if you are able to enact the statute for a third time.

Expanding the statutory cut-off period from six years to ten years is probably a good idea, at least politically. And it would not make much of a major difference as between the two figures.

I have some qualms about including the owner of real property in the class of persons protected by the 10-year period. I understand why that is included in view of the comments of your court in the earlier case. But, politically, if nothing else, that would be a blank check to protect owners who fail to maintain the property and thereby escape liability for that failure leading to injuries. The justification for a different treatment as between designers and constructors and owners was pointedly noted by the Connecticut Supreme Court in upholding that state's statute of repose --

> "It is our view that rational distinctions do exist between architects and engineers and others involved in the construction process. The owner of real estate has the continuing duty and ability to maintain the property after the architect or engineer has completed his work. With the passage of time it is more likely that any defect is caused by improper maintenance rather than defects in design. After acceptance by the owner, the architect or engineer ordinarily lacks control of the improvement." (Citations omitted- Sapata v. Burns, 342 A. 2d 700 (Conn. 1988)

Other courts have spoken similarly on the same point. But, as noted, I understand the reason for including owners. I would have some concern, however, that in a particularly egregious case down the road the courts might find the new statute unconstitutional for cutting off the right of a party injured through inadequate maintenance of the property, 15, 20 or even 30, or more, years after substantial completion.

The only thought I have to deal with this dilemma would possibly be to include some kind of specific legislative finding or policy in the statute's preamble to explain the legislative reasoning in not including owners in the protected class.

I will be very interested, of course, in future developments in this matter. Needless to say, if I can help in any way let me know.

Regards and best wishes,

Very truly yours,

MFL:sam

TALKING POINTS ON
WHY THE STATE OF NEW YORK NEEDS A STATUTE OF REPOSE

Buildings Can Last Forever

- The Empire State Building which was designed by Shreve, Lamb & Harmon was completed in 1931.
- The State of New York Capitol Building was completed in 1899. It was designed by Augustus Laver, Thomas Fuller and H. H. Hunt among others.
- Buffalo's Guaranty Building (recently renamed the Prudential Building) was completed in 1896, having been designed by Dankmar Adler and Louis H. Sullivan.

States Without Statutes of Repose Permit Their Architects to be Sued Forever

- In New York, which has no statute of repose, any architect can be sued by anyone for any injury, real or imagined, that occurred in or around a building designed by an architect.
- If any of the above named architects were alive today, anyone who tripped and fell in any of their buildings could sue them, alleging design defect caused the fall. This is so, even though millions of people have used the buildings from the day they were substantially completed without injury.

A State Without a Statute of Repose is Harming Architects and Architecture

- To protect themselves, architects have to store at great expense shopping carts full of contract documents for years on end on the off-chance someone may sue them.
- In a society as litigious as ours, a State without a statute of repose forces its design professionals to live with the constant anxiety of wondering if and when they will become victim to a person with a grievance.
- Good architecture requires architects to respond to the demands of modern technology. Unlimited liability delimits that response.
- An architect can only affect a building project while under contract to the project's owner to provide services. After substantial completion, the architect has no power to do anything with respect to that building. Eternal liability imposes responsibility on the architect, even after he has no authority or power to deter wrong-doing or otherwise protect the public.

- By way of comparison, while a New York architect faces eternal liability, a New York Class A unapprehended felon, such as an armed rapist enjoys a five-year statute of repose.

A State Without a Statute of Repose is Harming Its Public

- Unlimited architect liability provides the public strawmen to sue, but no real protection. A 1987 study of claims against New York architects shows that the farther in time from substantial completion the injury occurs, the less likely the architect will be required to compensate the plaintiff. In fact, in that study, all the claimants who received indemnity payments were injured within eleven years of building completion; 95% were injured within nine years of building completion. Claimants injured later than eleven years may have filed cases with courts, may have paid legal expenses, but they received no compensation from the architect's insurer.

- These statistics on indemnification suggest that the farther from substantial completion the injury takes place, the more likely it is caused by poor owner maintenance and not faulty design. For New York State to permit plaintiffs to sue architects years after substantial completion undermines owner incentive to maintain their buildings, as it transfers the burden of injury prevention from the owner to to the architect.

- In the absence of a statute of repose, plaintiffs' attorneys file suits against architects, unaware that the probability of client compensation decreases substantially the "older" the claim is. As a result, backlogged courts are further backlogged though no one is compensated for the effort, save for both sides' attorneys. Cases that could result in compensation for injured plaintiffs languish, awaiting their day in court.

Statutes of Repose Are Reasonable

- While six States, including New York, do not have statutes of repose, 33 States do. The constitutionality of these statutes have been upheld by those States' courts.

- Statutes of repose, when drafted carefully, balance the needs of society to protect all their citizens, including architects.

Statutes of Repose Can be Drafted to Meet Various Goals and Objectives

- If the New York State Legislature decides that "deterring architect wrongdoing" is the value to be protected, a six to eight year statute of repose is most reasonable. By six to eight years from the date of substantial completion, most architects who are going to be sued have been sued. And while, by and large, most architects are not found liable, if any architect is to be found liable, it is most likely an

architect from this group. In fact, 80 to 90 percent of the architects who are going to have indemnity payments made on their behalf will have been sued because of injuries that occurred within six to eight years of substantial completion.

- If the New York State Legislature decides that "deterring owner wrongdoing" is the value to be protected, a six to eight year statute is most reasonable. After that period, most claims involve users of the building -- third parties who have been injured most probably by negligent maintenance.

- If the New York State Legislature decides that "providing plaintiff compensation" is the value to be protected, a ten year statute of repose is most reasonable. Within this time most injuries (close to 95 percent) that are going to be compensated occur.

- If the New York State Legislature decides that "promoting commerce and architecture" is the value to be protected, a six year statute of repose is the most reasonable. The claims study shows that by year six, 96 percent of the claims are filed that involve parties to the design and construction process, such as owners, design professionals, contractors, material men, construction workers and the like. After that time, most of the claims involve third parties who use the building.

000 OMITTED
FROM FIGURES

BEST'S EXECUTIVE DATA SERVICE

1987 ALASKA

EXPERIENCE BY STATE
- OTHER LIABILITY

A2-02-17

COMPANY	MKT. SHR.	DIRECT PREMIUMS		DIVIDENDS TO POLICYHLDRS	DIRECT LOSSES		LOSS RATIOS			Group Rank		Overall Rank	
		WRITTEN w	EARNED e	DIRECT d	PAID p	INCURRED i	p/w	i/e	Adj.	Prem.	Ratio	Prem.	Ratio
AETNA LIFE & CAS GRP	1.8	1 168	1 366		87	864	7.5	63.3	63.3	8	9	15	30
AMER FINANCIAL GROUP	1.2	793	896		211	312	26.6	34.8	34.8	10	5	20	13
AMER GENERAL GROUP		8	8			3		32.0	32.0	23		71	
AMER INTERN GROUP	23.2	15 139	13 187		5 750	8 294	38.0	62.9	62.9	1	8	1	29
ATLANTIC MUTUAL COS		1	1			-1		-99.9	-99.9	28		91	
CHUBB GRP OF INS COS	1.9	1 255	1 168			212		18.1	18.1	7	3	14	7
CIGNA GROUP	6.9	4 509	4 282		-1 325	-3 209	-29.4	-74.9	-74.9	2		3	
CNA INS COMPANIES	4.4	2 878	3 111	7	481	1 571	16.7	50.5	50.6	5	6	6	20
COMM UNION INS COS		2	2			-14		-99.9	-99.9	26		86	
CONTINENTAL INS COS	1.5	967	960		1 515	-1 265	156.7	-99.9	-99.9	9		18	
CRUM & FORSTER COS	6.2	4 047	4 175		2 427	2 704	60.0	64.8	64.8	3	10	4	32
FIREMAN'S FUND COS	3.8	2 457	2 491	1	457	1 805	18.6	72.5	72.5	5	11	7	33
GENERAL ACC GROUP		1	11		1 865	1 155	999.9	999.9	999.9	27		89	
HANOVER INS COS		3	4					7.6	7.6	25		82	
HARTFORD INS GROUP	.9	565	618		2 881	3 880	510.3	628.2	628.2	12	16	24	42
HOME INS GROUP	1.1	739	566		4 359	1 789	589.5	316.2	316.2	11	15	22	41
KEMPER GROUP	.2	156	148			21		14.0	14.0	17	1	43	3
LINCOLN NAT GROUP		1								29		92	
NORTHWESTERN NAT GRP					-95	-100	999.9	999.9	999.9				
ORION GROUP	2.3	1 479	1 418			-54		-3.8	-3.8	6		11	
RELIANCE INS COS	.1	72	73		31	10	43.5	14.1	14.1	21	2	53	4
ROYAL INS GROUP	.5	348	297		1	-152	.3	-51.2	-51.2	14		27	
SAFECO INS COMPANIES	.3	170	134		27	75	15.9	56.0	56.0	15	7	40	21
ST PAUL GROUP	.1	74	106			34		31.8	1.8	19	4	51	10
TRANSAMERICA INS GRP	.2	133	105		12	78	9.3	74.3	74.3	18	12	44	34
TRAVELERS INS GROUP	.3	164	159		1 215	-523	738.8	-99.9	-99.9	16		41	
UNIGARD INS GROUP		5	24							24		80	
UNITED STATES F&G GR	.6	418	643		122	782	29.1	121.6	121.6	13	14	25	38
UTICA NATIONAL GROUP		11	6			2		32.7	32.7	22		68	
ZURICH INS GROUP-U S	.1	72	149			128		82.9	82.9	20	13	52	35
NATL.AGENCY COS 30=	57.6	37 635	36 106	8	20 021	18 394	53.2	51.0	51.0				
ALASKA NATIONAL INS	11.8	7 706	7 917		1 736	2 672	22.5	33.8	33.8	1	6	2	11
AMER MODERN HOME GRP	.1	63	63		4	9	7.0	13.9	13.9	27	2	55	2
AMERICAS INS CO	.3	215	266			604		227.0	227.0	14	18	32	40
W R BERKLEY CP GROUP	1.9	1 268	1 897		751	328	59.2	17.3	17.3	5	3	13	6
BERKSHIRE HATHAWAY	.5	345	543		7	75	2.0	13.8	13.8	11	1	28	1
CLARENDON INS GROUP	.1	42	42			52		123.4	123.4	28		56	
ELITE INS CO USB	.1	40	34			-1		-2.2	-2.2	29		58	
EMPLOYERS CAS GRP TX		14	24							34		66	
EMPLOYERS RE GROUP	.5	319	323		121	115	38.0	35.5	35.5	12	8	29	14
EVANSTON GROUP	1.5	1 009	1 231		282	481	28.0	39.1	39.1	7	9	17	15
FOREMOST CORP GROUP		32	45		32	14	98.5	30.3	30.3	30		60	
FREMONT INS GROUP		17	31		321	1 444	999.9	999.9	999.9	33		65	
GENERAL AGENTS GROUP	.3	177	187		4	-113	2.4	-60.5	-60.5	19		37	
GUARANTY NAT CORP GR	.3	173	96			33		34.8	34.8	20	7	39	12
HIGHLANDS INS GROUP	1.7	1 088	1 105		-157	-130	-14.4	-11.7	-11.7	6		16	
ILL. EXCH. COMPOSITE	.3	193	227			-190		-83.6	-83.6	18		36	
IMPERIAL CAS & INDEM		23	4		-5	-3	-20.6	-77.1	-77.1	32		63	
INTEGON CORP GROUP		14	1				1.0	32.1	32.1	35		67	
NORTH ATLANTIC C & S	.1	69	43			10		24.0	24.0	26		54	
NORTHLAND GROUP	2.3	1 522	1 200		7	737	.4	61.4	61.4	3	14	10	27
OLD REPUBLIC GROUP	1.2	775	1 329		567	1 401	73.1	105.4	105.4	8	16	21	36
PACIFIC MARINE GROUP	.9	582	979		294	-364	50.5	-37.2	-37.2	9		23	
PENN-AMERICA INS CO	.1	82	99		25	-4	30.3	-3.9	-3.9	25		50	
PROGRESSIVE GROUP	.2	103	76			44		58.1	58.1	22	12	47	24
PROVIDENCE WASH GRP	2.1	1 399	1 380		2 386	254	167.7	18.4	18.4	4	4	12	8
RLI GROUP	.1	96	59			66		111.6	111.6	23	17	48	37
ROCKWOOD GROUP	.6	377	443		25	203	6.5	45.9	45.9	10	11	26	17
SAFETY MUTUAL CAS CP	2.6	1 687	1 679		91	1 031	5.4	61.4	61.4	2	13	8	26
TOKIO MAR & FIRE GRP	.3	205	182		4	117	2.1	64.0	64.0	16	15	34	31
TOPA INS CO		11	40		14	65	122.1	160.9	160.9	36		69	
UMIALIK INS CO	.3	203	188		681	54	335.8	28.7	28.7	17	5	35	9
UNITED CAPITOL INS	.4	267	200			90		44.7	44.7	13	10	31	16
UNITED NATIONAL GRP	.2	110	85		500	781	454.3	895.9	895.9	21	20	46	44
WESTCO INS GROUP	.3	212	304		3 135	2 610	999.9	858.3	858.3	15	19	33	43
WILLIS FABER GROUP		25	39			4		11.4	11.4	31		62	
YASUDA FIRE & MARINE	.1	92	21			9	.1	41.6	41.6	24		49	
OTHER COS 33=	-.1	-76	-331		6 473	-1 745	-99.9	526.9	526.9				
STATE AGENCY CO 69=	31.3	20 479	22 052		17 258	10 733	84.3	48.7	48.7				
ALLSTATE INS GROUP	.5	298	275		50	168	16.9	61.1	61.1	4	6	30	25
COLONIAL PENN GRP		11	28		11	487	102.2	999.9	999.9	12		70	
CUNA MUT INS GROUP		32	32			3		8.7	8.7	10		61	
GEICO CORP GROUP		2	3					-6.1	-6.1	20		85	
GENERAL RE GROUP	2.6	1 671	1 616			1 006		62.2	62.2	2	7	9	28
JOHN DEERE GROUP	.3	174	144		13	83	7.3	57.6	57.6	5	5	38	23
LIBERTY MUTUAL GROUP	.3	164	170		61	27	37.2	15.9	15.9	6	1	42	5
MOTORS INS GROUP		21	23			29		125.7	125.7	11		64	
NATIONWIDE GROUP	5.9	3 826	3 774		2 115	1 898	55.3	50.3	50.3	4	3	5	19
NAVIGATORS INS CO	.1	41	19			13		65.0	65.0	8		57	
PRUDENTIAL OF AM GRP	.1	34	4		2	-93	7.1	-99.9	-99.9	9		59	
SENTRY INS GROUP		8	7					4.3	4.3	13		72	
STATE FARM GROUP	1.3	864	759		468	435	54.2	57.3	57.3	3	4	19	22
USAA GROUP	.2	115	123	8	4	56	3.3	45.8	49.2	7	2	45	18
OTHER COS 14=		-14	483		586	-335	-99.9	-69.2	-69.2				
DIRECT WRITERS 28=	11.1	7 247	7 460	9	3 310	3 776	45.7	50.6	50.7				
TOTAL = 127=	100.0	65 361	65 618	17	40 589	32 904	62.1	50.1	50.2				

REF 1 (PAGE)

000 OMITTED
FROM FIGURES

BEST'S EXECUTIVE DATA SERVICE

1987
ALASKA

EXPERIENCE BY STATE
– MEDICAL MALPRACTICE

A2-02-50

COMPANY	MKT. SHR.	DIRECT PREMIUMS		DIVIDENDS TO POLICYHLDRS	DIRECT LOSSES		LOSS RATIOS			Group Rank		Overall Rank	
		WRITTEN w	EARNED e	DIRECT d	PAID p	INCURRED I	p/w	l/e	Adj.	Prem.	Ratio	Prem.	Ratio
AETNA LIFE & CAS GRP	.8	130	130		500	-279	383.4	-99.9	-99.9	4		8	
AMER INTERN GROUP	2.9	447	298			158		53.0	53.0	2	2	5	5
CHUBB GRP OF INS COS					116	25							
CIGNA GROUP	.1	10	8		33	-379	345.2	-99.9	-99.9	8		15	
CNA INS COMPANIES	10.7	1 670	1 698		590	1 129	35.3	66.5	66.5	1	3	3	7
CONTINENTAL INS COS	.4	66	45			16		36.1	36.1	5		10	
CRUM & FORSTER COS		-2				-183		-99.9	-99.9				
FIREMAN'S FUND COS	.4	64	59			-21		-36.3	-36.3	6		11	
HARTFORD INS GROUP		2	4					.1	.1	9		19	
HOME INS GROUP													
ST PAUL GROUP	1.0	162	96			3		3.6	3.6	3	1	7	1
TRAVELERS INS GROUP	.4	59	59		-1	51	-1.7	86.3	86.3	7	4	12	9
NATL.AGENCY COS 12=	16.7	2 608	2 398		1 238	521	47.5	21.7	21.7				
W R BERKLEY GP GROUP	.2	34	31			25		82.3	82.3	2		13	
DOCTORS CO INTER EX		2	2							7		20	
EVANSTON GROUP	1.1	174	668			521		78.0	78.0	1	1	6	8
ILL. EXCH. COMPOSITE		4	1							6		18	
JEFFERSON INS GROUP		2	2			1		48.1	48.1	8		21	
MMI COMPANIES GROUP		5	2			1		68.0	68.0	5		17	
RLI GROUP	.1	9	8			8		96.1	96.1	4		16	
HESTCO INS GROUP	.1	13	18			-13		-72.9	-72.9	3		14	
OTHER COS 2=													
STATE AGENCY CO 10=	1.6	242	731			542		74.1	74.1				
ALLSTATE INS GROUP						773							
HEALTH CARE INDEMN	5.9	920	964		152	545	16.5	56.6	56.6	3	4	4	6
MEDICAL INDEMN ALASK	44.6	6 937	6 937		5 928	3 524	85.5	50.8	50.8	1	3	1	4
MEDICAL INS EXCH CAL	30.7	4 777	3 724		1 281	1 265	26.8	34.0	34.0	2	1	2	2
NAT CHIROPRACTIC MUT	.5	85	77			31		41.0	41.0	4	2	9	3
OTHER COS 1=						-1							
DIRECT WRITERS 6=	81.7	12 719	11 701		7 362	6 138	57.9	52.5	52.5				
TOTAL 28=	100.0	15 569	14 831		8 599	7 201	55.2	48.6	48.6				

TELECOPY COVER SHEET

Anchorage Legislative Information Office

Office - (907) 561-7007 Fax - (907) 562-4376

TO: House L&C FAX: 53 PHONE: _____

FROM: Anchorage LIO PHONE: 561-7007

INSTRUCTIONS: _____

RECEIVED: Date _____ Time _____

SENT: Date Mar 15 Time 5:24

DISPOSAL OF ORIGINAL: Discard ____ Hold for Pickup ____

NUMBER OF PAGES: 2 (counting cover sheet)

SENT BY: Mary Ann

FRANKLIN & [illegible]LLEN
Consulting Engineers

SUBJECT	LEGISLATIVE AFFAIRS
	HB 166 WORK SHOP. H.L.&C.
PREPARED BY	N. FRANKLIN
DATE	3-21-89
SHEET	1 OF 1
JOB NO	

1.) I AM TESTIFYING IN SUPPORT OF H.B. 166.

2.) MY SPECIAL AREA OF INTEREST IS THE INCLUSION OF A 6 YEAR STATUTE OF REPOSE. THIS STATUTE WAS IN PLACE UNTIL RECENTLY, AND IN FACT BY FAR THE MAJORITY OF STATES HAVE A SIMILAR STATUTE OF REPOSE FOR THE CONSTRUCTION INDUSTRY.

3.) NOT HAVING THAT IN-PLACE HAS GENERATED AN ATMOSPHERE OF UNPREDICTIBILITY AMONG THE DESIGN COMMUNITY AND HAS LEFT THE PROFESSIONAL DESIGNER SUBJECT TO POTENTIAL LAWSUITS FOR THE REMAINDER OF HIS LIFE.

4.) WITHOUT GETTING INTO CASES AND DETAILS I URGE PLEASE MOVE THIS BILL ON SO THAT WE CAN GET A STATUTE OF REPOSE IN PLACE THIS YEAR.

NELSON M. FRANKLIN P.E.

Nelson M. Franklin

FRANKLIN & ALLEN
Consulting Engineers

SUBJECT	LEGISLATIVE AFFAIRS
	HB 166 WORK SHOP. H.L. & C.
PREPARED BY	N. FRANKLIN
DATE	3-21-89
SHEET	1 OF 1
JOB NO	

1.) I AM TESTIFYING IN SUPPORT OF H.B. 166.

2.) MY SPECIAL AREA OF INTEREST IS THE INCLUSION OF A 6 YEAR STATUTE OF REPOSE. THIS STATUTE WAS IN PLACE UNTIL RECENTLY, AND IN FACT BY FAR THE MAJORITY OF STATES HAVE A SIMILAR STATUTE OF REPOSE FOR THE CONSTRUCTION INDUSTRY.

3.) NOT HAVING THAT IN-PLACE HAS GENERATED AN ATMOSPHERE OF UNPREDICTIBILITY AMONG THE DESIGN COMMUNITY + AND HAS LEFT THE PROFESSIONAL DESIGNERS SUBJECT TO POTENTIAL LAWSUITS FOR THE REMAINDER OF HIS LIFE.

4.) WITHOUT GETTING INTO CASES AND DETAILS I URGE PLEASE MOVE THIS BILL ON SO THAT WE CAN GET A STATUTE OF REPOSE IN PLACE THIS YEAR.

NELSON M. FRANKLIN P.E.

Mr. Kelly

Lawsuits' chronology accuses insurers of conspiracy on coverage

In the lawsuits accusing several of the nation's largest insurers with conspiring to manipulate the commercial liability market, the attorneys general of nine states present a picture of a behind-the-scenes conspiracy to restrict coverage. The insurers deny any wrongdoing. Here is a chronology of the events, as charged in the lawsuits:

■ In 1977, the Insurance Services Office Inc., an industry trade group, began a project to revise the standard commercial general liability policy form. The project resulted in a new set of policy forms that the ISO filed with state insurance regulators in March 1984. The ISO offered two variations: the traditional "occurrence" coverage, which pays for accidents occuring during the life of the policy even if the claims are filed years later, and a new "claims made" coverage, which pays claims made only while the policy is in effect.

■ Within ISO, Hartford Fire Insurance Co. and Allstate Insurance Co. unsuccessfully had opposed the new forms. The insurers urged the organization to adopt more restrictive policies. The Hartford, according to the suit, wanted the new forms to eliminate occurrence coverage and add a pollution exclusion.

■ After their positions were rejected, the lawsuit says, Hartford Fire and Allstate, together with Aetna Casualty and Surety Co. and Cigna Corp., began to pressure ISO to restrict liability coverage available to the consumer.

■ March 2, 1984, representatives of Hartford Fire met with representatives of General Reinsurance Corp. to develop a strategy to force changes in the new forms. The suit says the companies agreed to "derail" the forms unless ISO adopted their demands.

■ March 13, 1984, at a meeting of the executive committee of the Reinsurance Association of America, another trade group, General Re launched a "coordinated effort" with the reinsurance association to force revisions in the newly filed ISO claims-made form.

■ May 26, 1984, the reinsurance association's executive committee formed a special liability committee made up of five reinsurance companies. Reinsurers help insurance companies reduce their risk, agreeing to pay a portion of a policy's claims in return for some of its premium.

■ June 15, 1984, the special committee agreed to boycott the 1984 ISO forms unless a pollution exclusion was added and other changes were made to limit coverage.

■ June 19, 1984, in a letter to the ISO, the reinsurance association said its members would not provide reinsurance for insurance written on the 1984 ISO forms.

March 2, 1984, representatives of Hartford Fire met with representatives of General Reinsurance Corp. to develop a strategy to force changes in the new forms.

■ June 21, 1984, Thomas A. Greene & Co. Inc., a New York-based broker, spoke to the ISO board of directors and, at the suggestion of Hartford Fire and General Re, "conveyed the boycott message."

■ At the same time, the suit says, Hartford Fire, Aetna, Cigna and Allstate encouraged a boycott of the forms by key Lloyd's of London syndicates.

■ In July 1984, ISO representatives visited London to explain and promote the new forms. Before the trip, the lawsuit says, Hartford Fire and Allstate worked with Greene and another broker to coordinate the London reinsurers' response to the forms.

■ July 4, 1984, at a dinner hosted by the ISO at the Garrick Club, a private men's club, London reinsurers threatened a boycott of the 1984 forms unless changes similar to those demanded by the Reinsurance Association of America were made.

■ After returning from London, ISO staff met with Hartford Fire at its headquarters in Hartford.

■ Sometime between Aug. 12 and Aug. 22, 1984, ISO staff agreed to reconsider changes in the 1984 forms.

■ Sept. 20, 1984, the ISO executive committee met, with representatives of both the foreign and domestic casualty reinsurance markets in attendance. This was the first time representatives of the markets had been invited to speak at an ISO executive committee meeting. The representatives presented their stance: Change the 1984 forms or no reinsurance. The executive committee agreed to make two changes to the forms, including the exclusion of all pollution coverage, but it did not change its plan to offer a new occurrence form.

■ After the meeting, Lloyd's reinsurers continued to work to eliminate use of the occurrence form. Among other strategies, they said in public forums and the trade press that there would be no reinsurance for coverage written on the occurrence form.

■ The lawsuit says the London reinsurers also boycotted reinsurance for pollution liability coverage, even if written on claims-made forms. Lead reinsurance underwriters in London met Nov. 6, 1985, and agreed that all North American casualty contracts would be written with a pollution exclusion.

New York Stock Exchange Issues

Continued from previous page

Sales Net | Sales Net | Sales Net

DATE: April 13, 1989

FROM: Kathleen Dinius, Ph.D.
35477 Spur Highway, Suite 209
Soldotna, AK 99669
262-1260

TO: Juneau LIO
House Labor and Commerce Committee
House of Representatives
Alaska State Legislature

RE: House Bill No. 166

TIME: 3:30

TOTAL NUMBER OF PAGES INCLUDING COVER: 8

OTHER INSTRUCTIONS:

The following is requested to be included as written testimony on the hearing on House Bill 166 in House Labor and Commerce Committee

KATHLEEN DINIUS, PH.D.
LICENSED PSYCHOLOGIST
35477 SPUR HIGHWAY, SUITE 209
SECOND FLOOR, 4-D COMMERCIAL BUILDING
SOLDOTNA, ALASKA 99669

907-262-1260

April 13, 1989

House Labor and Commerce Committee
House of Representatives
Alaska State Legislature

RE: House Bill No. 166

Dear Committee Members:

On April 1, 1988, I attended a statewide teleconference on House Bill No. 166. During that session, I testified regarding the psychological effects to individuals who have been injured and experiencing enduring effects of those injuries. I was asked if I would provide additional information about this to members of the Legislature. I am happy to do so.

I am a licensed psychologist in the State of Alaska. I am also licensed as a psychologist in the states of Wisconsin and Indiana. I have worked in the community mental health systems in Indiana and Alaska for eighteen years. I am currently in private practice in Soldotna. During my career, I have worked with a fair number of clients who have experienced chronic pain and physical limitations as the result of injuries they have sustained. I have counseled with them to help them deal them with the emotional, social and physical consequences of these injuries.

Individuals who have sustained injuries that are either acute and traumatic in nature or which are long-term in their effects almost always experience some psychological consequences along with the physical ones. Most frequently, people experience anxiety, depression, or both. The anxiety often is connected with the actual event which caused the injury. For example, individuals injured in a car may develop a fear of driving or riding in cars. One client with whom I have worked developed phobias of being in small places after she was injured by chemical fumes in a bathroom. The anxieties can generalize to many situations and hamper many apparently unrelated, common everyday life experiences for these individuals. If there has been any physical disfigurement, the individual must also face anxiety about the reactions of others to their physical appearance. Because accidents may lead to injuries which prevent people from continuing to work, they are often also beset with financial troubles and the inability to provide an income for themselves and their families. This can lead to anxiety on the part of the injured person, tension in the marriage and family, and depression on the part of the wage earner who can no longer provide support for the family. The latter is most intense for men, as they have much greater difficulty accepting an inability to follow through on their role as bread winner.

When an individual must sustain long-term consequences of an injury, or if they experience chronic pain, they usually develop symptoms of significant depression in addition to any symptoms of anxiety they may have. Even relatively mild pain becomes very wearing on the individual if it is of a chronic nature. People begin to become focused on the pain in an effort to find relief for it. They have difficulty accepting the limitations of activities, as do those around them. Family members often become angry at the injured person because he or she can no longer engage in many family activities with them. The injured individual may feel guilty about their limitations and they may also become angry at family or friends who do not understand their position. This is especially true if the injured person does not physically appear to be injured, that is if they have an injury such as a back injury that is not immediately to others. Although the injured person is preoccupied with the effects of his injury and the pain he experiences, others begin to tire of hearing him talk about it. Eventually, the injured person may withdraw from social contacts. I am enclosing a copy of a section of the book Mastering Pain by Richard A. Sternbach. Dr. Sternbach has done research on pain since 1960 and has worked with pain patients since 1964. He has been the director of the Pain Treatment Center at the Scripps Clinic and Research Foundation in California since 1975. Dr. Sternbach gives an excellent description of what happens to individuals who experience chronic pain as they progress from the initial stages through the enduring stages of their condition.

Individuals who have been permanently impaired or disfigured have additional problems in dealing with the fact that they are no longer the person they were before. They must go through the trauma of looking different physically and redefining their concept of themselves. If they experience paralysis or inability to use parts of their body, including senses and speech, they must totally reorganize their lives. They experience the depression of giving up and grieving for the life they had expected to have. Even more acute are the effects of individuals who sustain brain damage which affects body motion, speech, use of mental functions and processes or emotional control. Not only must these individuals deal with the fact that they are no longer the same person they were prior to their injury, they must also often do this with limited mental abilities. When a person must cope with the experience of losing his losing his sense of self, the resulting depression and anxiety can be intense and very real.

There are many repercussions for individuals, particularly family members, where a death is involved. Most extreme of these is the case of a child dying. Even the death of an adult child is extremely difficult for the parent to handle. However, the death

of a minor child usually creates extreme emotional distress for family members and particularly for the parents. The Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association classifies the death of a child as a catastrophic stressor. It is classified in the same level as having experienced a concentration camp. It is the most extreme of stressors. Likewise, for a child experiencing the death of both parents, this is also categorized as catastrophic. The death of a spouse or the death of one parent in the case of a child is listed as extreme, which is the next most severe classification of stressors. In the case of the death of a child, even where the parents had no fault in that death, divorce of the parents is common. Parents go through stages of blaming themselves, blaming the other spouse, and simply having difficulty accepting the child's death at all. These consequences can follow and frequently do follow the parents for years, sometimes throughout their lifetime. As parents who have lost children have told me years later, nothing and no one ever replaces their child.

I appreciate the opportunity to provide this information to you. Knowing the distress that individuals experience in these kinds of tragedies, I would ask you to consider these factors when making decisions about House Bill 166. Particularly pertinent is the section for compensation to individuals or family members which are not based on medical costs or loss of income. Although compensation for emotional distress cannot stop that distress from happening, it can help the individual have the means and opportunity to do some restructuring of their lives. If you have any questions about what I presented or would wish to talk with me further, I would be most happy to talk with you. You could contact me at 262-1260 during daytime business hours or at home at 262-1058.

Yours very truly,

Kathleen Dinius, Ph.D

Kathleen Dinius, Ph.D.
Licensed Psychologist

KD/mp

Also by Richard A. Sternbach, M.D.:

PAIN PATIENTS: Traits & Treatments
THE PSYCHOLOGY OF PAIN
THE PSYCHOLOGY OF PAIN, 2nd ed.

MASTERING PAIN

A Twelve-step program for coping with chronic pain

by Dr. Richard A. Sternbach

BALLANTINE BOOKS • NEW YORK

What Chronic Pain Does to Us

Probably the commonest complaint of those with chronic pain is that their sleep is disturbed. Before the pain began, they always slept well. Since the pain developed, they have trouble falling asleep because they cannot get comfortable. As they finally settle into a less uncomfortable position, they find the pain becoming more prominent in their minds as there is less to distract them. Finally, exhausted, they drift into a restless sleep, only to awaken every hour or so as they roll over or change position and the pain awakens them.

They finally remain awake until three or four in the morning, unable to get back to sleep, and at such times find it impossible not to think about what the pain means—whether the doctors have made an incorrect diagnosis or are keeping some terrible secret, whether it is worth trying to go on living with such pain, whether there is any other way out.

Even the minority who are able to sleep well report that they feel quite exhausted all the time, drained of energy as though they had the flu. The continuous pain wears them down. If, in addition to this fatigue, there is the disturbance of sleep, the people feel even less able to bear the pain; indeed, they become less tolerant of any pain. Even minor injuries, such as those caused by bumping into a piece of furniture or stubbing a toe, seem like major calamities.

Usually those with chronic pain are taking analgesics. One of the side effects of such drugs is to upset the stomach and gut. Patients frequently complain of heartburn and constipation, feeling nauseated and bilious. They find the analgesics becoming less effective over time; they need to take larger amounts just to "take the edge off" the pain, and so still more severe side effects develop.

How miserable these people feel. In addition to being

in pain, they are tired all the time, they cannot sleep and their bowels don't function properly. And yet these physical problems are only part of the chronic-pain syndrome. There are psychological effects too.

Those with chronic pain complain of having become very irritable and short-tempered. They find themselves flaring up in anger over the minor actions and trivial comments of those around them. They say hurtful things to family members for insufficient reasons, then feel guilty and promise to keep their tempers and hold their tongues, only to lose control again and again. They then begin to seclude themselves to avoid further attacking those they are close to. They thus find themselves withdrawing more and more, often becoming almost homebound, sometimes even spending most of the time in the bedroom, alone, with little to distract them from their pain.

Some persons with chronic pain feel so nauseated by their pain and analgesics that they lose their appetites, need to force themselves to eat a minimum amount of food and slowly but steadily lose weight. Others find themselves restless and on edge and do a great deal of nervous snacking and excessive eating. This, combined with their inactivity, causes them to steadily gain weight, often becoming somewhat obese, and to become disgusted with themselves.

The disturbances of sleep and appetite and the resulting social withdrawal are some of the elements underlying depression. Almost all reports of psychiatric and psychological studies of chronic-pain patients report significant depression as one of the results. It is not exactly the same as the kind of depression that psychiatric patients show, but it is a depression nevertheless. Some of the persons with chronic pain admit to feeling depressed, but many do not, insisting that it is pain and not depression that spoils their sleep, makes them withdraw and so on.

In addition to this kind of depression, many of those with chronic pain begin to think of themselves as chronic invalids or, at least, chronically disabled. They are often unable to continue working, and receive disability or workers' compensation income, which only partly compensates for the lost salary or wages, and this begins to contribute to a shift in the family dynamics and power structure.

With one of the wage earners unable to bring in the accustomed income, unable to help with the household chores and more and more withdrawn, the center of the family shifts away from the person with pain to those who are more active and involved, and the patient becomes (and feels) less important. The other family members, for their part, feel sorry for the one with pain, frustrated and guilty because they cannot help relieve the pain and—so secretly that they hardly admit it to themselves—somewhat resentful that they have to do more chores now.

Some families remain in this state of strain and tension. In others, the patient begins to lose his or her sense of status and, without realizing it, begins to tyrannize the family. This may occur directly, through irritability and temper outbursts, or indirectly, through manipulating others to do things the person could do for himself or herself. These manipulations are made possible through the guilt feelings of the family members, who are powerless to help the sufferer and resent his or her disability.

The physical problems (sleep disturbance, appetite disturbance, fatigue, etc.) and psychological problems (irritability, depression, social withdrawal) and family problems are serious enough, but that is not all there is to the chronic-pain syndrome. There are serious prob-

lems as well with doctors, with the health-care system and with the insurance and disability systems.

The person with chronic pain usually has a much higher proportion of medical contacts than do other patients. Because, despite the patient's insistent requests, the physician cannot provide relief, the patient may begin soliciting help from other physicians, requesting intervention in the form of surgery or analgesic prescriptions. The doctors become frustrated because their ability to cure or at least provide relief is stymied, and they begin to wonder whether the patient is or will become a drug addict, or whether psychological symptoms may be causing the pain. The patient and physician become increasingly irritated and frustrated with each other, and mutual suspicion begins to develop.

Partly in desperation, partly because of hope, the patient begins to try alternative health-care systems. Various forms of massage and manipulation, nutritional plans and food supplements are tried, with some possible slight but temporary improvement noted. As the patient reports this to his or her doctor, the physician becomes more annoyed, and notes about the patient's emotional problems and drug use become more prominent in the record. The medical-insurance or health-plan system begins not only to refuse reimbursement for the nontraditional treatments the patient has received, but to question the need for even the more orthodox medical treatments.

Many patients begin to find that much of their time is spent filling out claim forms. Not only are requests for reimbursement of medical expenses slow in being filled, but more and more of them are being denied and must be appealed. Disability checks suddenly stop arriving, without explanation, and the patient learns only weeks or months later that this is due to a casual comment by one or another physician to the effect that she or he does not think the patient is really all that disabled, and that

psychological factors seem to be prominent in the case. Some patients find themselves being followed and photographed by insurance investigators who are hired to take films of the patient to prove that he or she is not really disabled. The patient becomes increasingly angry and embittered and—like it or not—poorer.

The chronic-pain syndrome consists of the physical, mental, familial and social problems we have just described. These are not imaginary. They do not cause the pain, but they certainly make the pain seem worse and harder to deal with. They do cause *excessive* pain and *excessive* disability. We will deal with these problems specifically and in some detail in later chapters. At this point we are only mentioning them to give an idea of the extent of the problem and to help you to realize that the problems you may have encountered are not unique, but are well known. And furthermore, there are specific ways of dealing with them that make it possible to have better means of pain control and to live a more satisfying life.

But the effects of chronic pain on the individual and the family and on social contacts are still only part of the story. There are many such individuals, and when the total costs of acute and chronic pain are estimated, they are truly staggering.

What Is Pain?

Each of us believes that we know, from our own experiences, what pain is. But different persons have different experiences, and the word "pain" may mean something different to each one of us. The following definition is the one adopted by the International Association for the Study of Pain.

Pain is an unpleasant sensory and emotional experience associated with actual or potential tissue damage,

Attachment 1A
FCC 86-2172

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

August 8, 1986

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

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

Dear Mr. Gray:

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

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

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

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

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

Sincerely,

Thomas L. Rudd

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

BODILY INJURY CLAIM COST IMPACT OF FLORIDA TORT LAW CHANGE

Summary

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

Impact of Tort Law Changes

Impact of Tort Law Changes

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

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

Claim Study

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

1. Commercial Casualty claims (excluding National Accounts business) for policy years 1981 through 1985
   a. reported prior to January 1, 1986
   b. open as of May, 1986
   c. closed during the last six months

2. All claims in category (1) with indemnity payments or reserves over $25,000 were analyzed (total of 55 claims).

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

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

Collateral Source Analysis

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

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

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

Joint and Several Analysis

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

Analysis of Limitation of Noneconomic Damages to $450,000

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

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

Analysis of Punitive Damages

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

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

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

1. interaction of policy limits, past economic losses, and future economic losses

2. settlement value of the case

3. apparent implicit recognition of the periodic nature of future damages

Overall Summary

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

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

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

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

ADDENDUM

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

Evaluation:

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

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

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

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

Comments on other provisions of the bill:

a. Collateral source offset

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

b. Itemization of Damages

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

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

ADDENDUM
(Continued)

c. Frivolous Suit Protection

This provision can either work for or against us depending on who wins the case. No savings are expected from it.

d. Additur/Remittitur

This provision can also work for or against us. No savings are expected.

e. Punitive Damages

The legislation reduces the monetary incentive for punitive damage cases, but not total award amounts. Since these cases often have a retaliatory incentive, no savings are expected.

f. Timing of Effects

The tort changes made in Florida apply to losses occurring on or after July 1, 1986. On a claims-made policy, they will effect only the portion of our expected losses with accident date after July 1, 1986. This will impact the equivalent of our first year losses.

g. Conclusion

The tort law changes effective July 1, 1986 in Florida will, hopefully, have a positive impact on loss costs for occurrences after that date. However, to forecast the effect is highly speculative. Our evaluation of prior losses showed little or no savings under key provisions of the law and our analysis of other provisions show no expected savings. Our best estimate is no effect from the tort changes.

It can be hoped that the adoption of these tort changes will have an intangible effect on society, and further work to mitigate future loss trends. However, the trends in medical malpractice have been very high. The effect of the reform needs to be very strong to stem such trends.

Attachment 2

State Farm Fire and Casualty Company

State Farm General Insurance Company

112 E. WASHINGTON ST.
BLOOMINGTON, ILLINOIS 61701

October 21, 1986

Mr. Ray Rathert
Kansas Insurance Department
420 S. W. 9th Street
Topeka, Kansas 66612

Ray:

Before any discussion of State Farm and tort reform, it must first be clearly understood that most of the problems in the liability field are in lines which State Farm does not write. Because of this, the impact of tort reform on our book of business is going to be considerably different from that of a major liability writer.

We have been requested by several insurance departments to come up with some estimate of the effect of newly passed tort reform ~~legislation on our~~ rates in their states. We know of no way this can be done actuarially. Consequently, we resorted to judgement.

The few enacted tort reform statutes usually include items such as:

1) Collateral source of indemnity

2) A non-economic cap

3) Joint and several restriction

4) Punitive damage limitation

5) Alternate methods of payment.

A sampling of commercial liability claims provided the following:

1) Collateral source of indemnity. The sample indicated that approximately 7% of our total indemnity losses were potentially subject to a collateral source. Only about a quarter of these reflected a known collateral source. In our judgement, 50% would be a very liberal estimate of the success in reducing damages due to the existance of a collateral source. The net savings from the collateral source change is thus about 1% (7% X 25% X 50%).

2) Non-economic cap. Non-economic caps are established at such a level that our sample indicated only very few claims would exceed the cap. It is our judgement that the loss savings resulting from the non-economic cap will not exceed 1% of our total indemnity losses.

3) Joint and several restriction. In our sample of liability claims, no claim was found that would have been affected by the joint and several restriction.

4) Punitive damage limitation. Again, in our sample, no punitive damage awards were found.

5) Alternative methods of payment. On our book of business, the savings due to alternative payment methods on future economic losses would be negligible in relation to our total indemnity losses.

Although we believe the effect of tort reform on our book of business would be small, we do believe that effective tort reform legislation can have a positive impact on not only pricing but also availability. It is important to keep in mind that tort reform, or absence thereof, is only one of many factors which influence pricing and availability. Any of these other factors can produce an opposite effect which could equal or outweigh any positive effect of tort reform.

Attached are liability rate comparisons for Kansas and surrounding states. As you know, we use ISO rates for monoline policies. Even in our package policies, the original liability loadings were also derived from ISO rates.

Again, as you know, we do review our rate levels at least annually. It will probably be several years before any effect from tort reform legislation can be expected to influence our experience. Anyway, hope these brief comments will be of some use to you in your discussions of this subject.

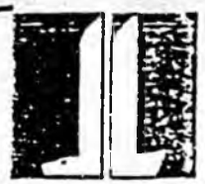
Best regards,

Bob

Robert J. Nagel
Assistant Vice President
State Filings Division

RJN:kc/1021

Attachment 4



GREAT AMERICAN·WEST, INC.

200 S. MANCHESTER AVENUE
ORANGE, CA 92668
714/634-4600

April 23, 1986

Mr. Norman Figon
Rate Analyst
Washington Insurance Department
Insurance Building
Olympia, WA 98504

Re: American National Fire Insurance Company
Select Driver I Program
Select Driver II Program
Private Passenger Automobile
Rate and Rule Revision

Dear Mr. Figon:

In your letter of March 25, 1986, you indicated that we need to place a provision in our ratemaking to reflect the impact of the "tort reform" law. As an attempt to quantify, we reviewed twenty-four claim files, which represented all of our Private Passenger Automobile claims over $50,000 in the state of Washington since 1983. Of these twenty-four claims, we believe that the new law could have an impact on three claims. One claim involved a driver that was intoxicated. We estimate that we would not have paid $20,000 of the claim. On the other hand, there were two claims in which American National Fire would see an increase in its loss liability. These are contributory negligence cases in which our percent of the entire loss liability would increase. The impact of the law on these two is at least $100,000 on each of them.

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

We request, therefore, that you reconsider the original filing of January 19, 1986, with an amended effective date rule of:

"For all policies written on or after June 2, 1986".

In our telephone conversation you mentioned a concern that we are selecting an increase less than our indications. Our plan of action is to take this increase, which we estimate to be slightly more than 14%, and to review the rates in the near future, such that we can effect a rate change six months after the effective date of this revision. We believe that this method will prove to be less disruptive on our book of business than other courses that we might have chosen.

We hope the above includes all the information that you need to expedite an approval of the filing.

Sincerely,

Kevin J. Kelley
Director of Actuarial

KK/nk

CHIEF EXECUTIVE
circular

Attachment 5

	DIB
	~~KHC~~
	RAI
	~~WFSC~~
	~~KAS~~

October 3, 1986

ISO POLICY DECISION ON TORT REFORM ANNOUNCED

Chief Executive CE-86-31

BACKGROUND

Various tort reform measures have been enacted or are still under active consideration in many states. It is clear that meaningful tort reform will have a favorable, prospective impact on loss severity and/or frequency, variable by state and line of insurance which, ultimately, will be reflected in state loss experience.

However, in some jurisdictions, an immediate rate reflection in response to tort reform is being demanded. Statutes in Florida, New York and Hawaii mandate that insurers reflect tort reform legislation in their filings. The New York Insurance Department has already advised companies of its estimates of the cost reductive effects of tort reform. Florida has mandated a 1987 rollback to adjusted 1984 rates, unless companies file 1987 rates reflecting the impact of tort reform by October 15, 1986. Hawaii has mandated a 10% decrease in rates on October 1st to reflect tort reform, with further reductions required in future years. The Washington Insurance Department is requiring that future rate filings reflect enacted tort reform even without a specific statutory requirement.

Insurance Services Office, Inc., 160 Water Street, New York, New York 10038 (212) 487-5000

ISO POSITION

ISO is unable to quantify, and to reflect in its filings with a reasonable degree of certainty, any immediate cost effects of tort reform. ISO believes that the reflection of any beneficial effect of tort reform on insurance pricing, where mandated, is a matter of individual insurer judgment and not a precise actuarial exercise. Such judgment is consequently more properly applied by individual insurers, rather than by ISO in its role of acting on behalf of those affiliated insurers which elect to use ISO's services.

Therefore, the ISO Board of Directors has established — as ISO policy — that, inasmuch as ISO cannot immediately reflect any cost effects of tort reform in its filings, any such effects are best determined by the judgment of each insurer, taking into account the distribution by coverage, class, and limits on its own book of business.

ISO ACTION

Consistent with this policy, ISO advisory rates will not reflect tort reform and each company must make its own assessment as to the immediate effect, if any, of tort reform on its book of business.

In New York, in order to assist companies in complying with the refiling requirements of the new law, ISO released Commercial Lines Circular CL-86-29 which contained revised manual rules utilizing the cost reductive effects promulgated by the Superintendent of Insurance, without commenting on their appropriateness.

In Florida, ISO has developed a filing procedure -- which has been approved by the Insurance Department -- whereby individual companies must supplement the ISO filing with their own individual estimates of the impact of tort reform. At the direction of the Insurance Department, ISO will collect these individual estimates and file them on behalf of each insurer. Refer to ISO Commercial Lines Circular CL-86-33 for specific details.

ADDITIONAL INFORMATION

ISO plans to shortly provide insurers with information which could be considered by each company in reflecting any effect of tort reform, including an analysis of the tort reform measures enacted in individual states.

Within the next several days, ISO will release such information to insurers via Commercial Lines and Technical Services Circulars. In anticipating receipt of this material, each insurer should note ISO's strong belief that any beneficial effects of tort reform cannot be quantified with any degree of accuracy. Accordingly, providing any quantitative information does not imply that any actuarial precision can be applied to what is -- in effect -- an imprecise subject. However, the information may aid individual insurers in supplementing their judgment which, ultimately, will be the major factor in determining any beneficial pricing effect of tort reform.

CAUTION

In Circular CL-86-33 we detailed the Florida filing procedures which must be completed by October 15th. Since -- to avoid the rollback -- Florida rate filings require individual insurer estimates of the cost effects of tort reform and, since the judgment of each insurer will be the major component in arriving at these estimates, we urge individual insurers to promptly begin developing their own estimates, without waiting for the ISO material on tort reform which, as heretofore mentioned, will not produce precise results.

Daniel J. McNamara
President

cc: ISO Board of Directors
Actuarial Committee
Commercial Lines Committee
Personal Lines Committee

Attachment 3

NATIONAL INSURANCE
CONSUMER ORGANIZATION

Effect on Insurance Rates of Florida Tort Reforms -

for all companies filing as of 11/01/86

% Reduction	Number of Filings				
	Commercial General Liability	Commercial Package	Auto	Other	Total
Ø	72	28	31	44	175
Ø-2.5%	12	25	5	3	45
2.5-5%	18	14	6	Ø	38
5-7.5%	7	1	7	1	16
7.5-1Ø%	2	1	Ø	Ø	3
Over 1Ø%	Ø	Ø	Ø	Ø	Ø
Total number of filings	111	69	49	48	277
Average Reduction	-1.3%	-1.5%	-1.5%	-Ø.2%	-1.2%

Average calculated by assuming all filings are of equal premium weight. Companies that filed rates and did not calculate the effect of the new tort reforms are not included.

Source: Florida Department of Insurance

121 N. Payne Street
Alexandria, Virginia 22314
(703) 549-8050

Attachment 6

INSURANCE SERVICES OFFICE

160 WATER STREET NEW YORK, N. Y. 10038

TELEPHONE: (212) 487-5000

COMMERCIAL CASUALTY ACTUARIAL DIVISION
RICHARD B. MONDI, ASSOCIATE ACTUARY & MANAGER

October 15, 1975

Mr. Stanley A. Dorf, Chief Actuary
New York Insurance Department
2 World Trade Center
New York, New York 10038

Re: Comparative/Contributory Negligence -
Automobile Liability Rate Change Proposal

Dear Mr. Dorf:

Because of the change in the New York law from contributory negligence to comparative negligence, I.S.O. proposes to increase Automobile Liability (including Uninsured Motorists) rates by 5%. This proposed increase is based on a study of closed Automobile Liability claims in California, comparing the actual settlement under the comparative negligence law with the estimate of what it would have been under the earlier contributory negligence law. Enclosed is Exhibit 1 displaying the indicated rate changes by line and coverage based on the survey, and also the proposed changes of 5% for the liability coverages and "no change" for Personal Injury Protection. Exhibit 2 details the results of the claim study survey, showing number of claims, losses under both negligence laws, and comparative/contributory ratios, by line and coverage.

We have also enclosed a copy of the "Call" letter used for this survey; in it can be found a sample copy of the questionnaire form and the general instructions for completing the form. The companies participating in the study write approximately 75% of the Automobile Liability premiums written by Insurance Services Office affiliated companies. All claims reported to us were settled very shortly after the changeover in negligence laws in California; thus, claims personnel completing these forms were in a good position to compare comparative vs. contributory settlements for their claims.

Very truly yours,

George Burger

GB:cm
Enc.

George Burger
Actuarial Assistant

New York

Automobile Liability Insurance

I.S.O. Proposed Rate Increases to Reflect the Change from Contributory to Comparative Negligence*

Coverage	Indicated Rate Change	Proposed Rate Change
Private Passenger		
Residual Bodily Injury	+ 4.1%	+ 5.0%
Personal Injury Protection	-	0.0
Property Damage	+ 4.6	+ 5.0
Uninsured Motorists	+13.0	+ 5.0
Total	+ 4.8	+ 4.4
Commercial		
Residual Bodily Injury	+ 6.8%	+ 5.0%
Personal Injury Protection	-	0.0
Property Damage	+ 6.9	+ 5.0
Uninsured Motorists	+ 0.1	+ 5.0
Total	+ 6.5	+ 4.7
Grand Total	+ 5.4%	+ 4.4%

*Note that all percent changes are weighted on New York's premium distribution.

AUTOMOBILE LIABILITY INSURANCE
Effect of Change from Contributory to Comparative Negligence*

Coverage	(1) Number of claims	(2) Losses Under Contributory Negligence	(3) Losses Under Comparative Negligence	(4) Ratio ((3)÷(2))
Private Passenger Automobiles				
Bodily Injury	521	$1,098,811	$1,144,407	1.041
Property Damage	1,622	574,730	601,305	1.046
Uninsured Motorists	43	101,872	115,072	1.130
Total	2,186	$1,775,413	$1,860,784	1.048
Commercial Automobile				
Bodily Injury	318	517,285	552,522	1.068
Property Damage	1,018	361,123	386,135	1.069
Uninsured Motorists	9	48,305	48,339	1.001
Total	1,345	926,713	986,996	1.065
Grand Total	3,531	$2,702,126	$2,847,780	1.054

* NOTE: The above experience was taken from ISO's California Closed Claim Survey.

CLAIMS NEWS

MICA Medical Indemnity Corporation of Alaska

June 1988

THE ALASKA SUPREME COURT: Believe It Or Not!

This issue of CLAIM NEWS is devoted to articles highlighting recent decisions by the Alaska Supreme Court and cases in which those decisions have factored prominently.

Critics of the insurance industry, who would have the public believe that the current crisis in liability insurance is simply a contrivance of the industry to justify higher premiums and greater profits, should consider the impact these decisions have on insurance companies and their clients. For example underwriters of hospitals in 1981, the year in which Jackson was injured, collected premium for that and subsequent years that could hardly have anticipated or reflected the exposure dumped on Alaskan hospitals in October of 1987, when the Court made hospitals responsible for E.R. physicians. Companies, such as MICA, having spent years building a claims department based on in-house expertise, could hardly have anticipated or budgeted for the enormously increased defense attorney costs necessitated by the Langdon vs. Champion decision.

The decisions of the Alaska Supreme Court, generally acknowledged to be one of the most, if not the most, liberal high court in the land, factor prominently in MICA's cost of doing business and, consequently, in its premium structure. It is interesting that our several-year experience of diminished severity and frequency of claims continues; but the cost of doing business, including defense attorney costs, escalates.

The crisis in the insurance industry is a complex one with many facets. Certainly, physicians are part of the problem and need to increase their awareness of, and attention to, management of risk in their own practices and the achievement of quality patient care. We believe that Alaskan physicians, particularly MICA policyholders, have been responsive to this company's efforts in risk management and that is one of the primary causes of the diminished frequency and severity of claims. To be sure, there is work left to be done in that direction, but the legislative, executive, and particularly the judicial branch of government in this state play an enormous role in the problem which should be recognized and for which they should be held accountable.

Supreme Court Decision Raises Discoverability Concern Over Adjuster's File

In early April of 1988, the Alaska Supreme Court handed down a decision in a case entitled Langdon v. Champion. In this case the court dealt with the familiar question of what parts of an insurance adjuster's file are subject to discovery in a suit brought by a claimant against the insured.

The action did not involve a professional liability issue. It involved a personal injury claim against the defendant insured. The defendant's insurer became aware of the plaintiff's claim some nine months after the incident and immediately an adjuster took a recorded statement from the insured. Over the ensuing months and prior to the filing of suit, the adjuster corresponded with the claimant's attorney. At the time suit was filed, the defense was assigned to legal counsel.

The plaintiff made a request for production of all recorded and written statements, investigative reports and a complete copy of the adjuster's file. The trial court denied the motion to compel production. Plaintiff filed a petition for review with the Alaska Supreme Court which was granted.

The court considered, first, whether the defendant's recorded statement was protected by the attorney-client privilege. The court concluded that an insurer was not a "representative" of an attorney under the Alaska Rules of Evidence and concluded that statements made by an insured to his insurer were not protected by the attorney-client privilege and were, therefore, discoverable.

Secondly, the court discussed the work product privilege applicable to materials prepared in anticipation of litigation and held that materials contained in an insurer's files would be conclusively presumed to have been compiled in the ordinary course of business absent a showing that they were prepared at the request or under the supervision of the insured's attorney. In other words, prior to attorney involvement, materials held by insurers are subject to discovery without regard to any work product restrictions.

This decision has profound and very worrisome implications for MICA. In many types of insurance the work product of the adjuster in investigating and evaluating the case may not be very informative to plaintiff's attorney. In MICA's case, we have always prided ourselves as a company having the claims staff and physician peer review committees necessary to carry out intense early investigation and analysis prior to involvement of legal counsel. This has resulted in not only a better work product but in susbstantial cost containment. Claims staff and physician peer review committees have done what they do best, namely the investigation and analysis of claims of medical negligence. Attorneys have been reserved to do what they do best, namely defend law suits.

continued on page 2

Duty of Confidentiality

A recent New York case generated a good deal of concern among Alaskan physicians as to whether or not medical records could be supplied to their professional liability insurance company without risking a suit for breach of confidentiality. The decision reached in the trial court was worrisome but has recently been overturned in the New York appellate court. It seems timely to review the facts of the case, the lower court's reasoning, and the reversal by the appellate court.

FACTS OF CASE

The patient's attorney sent a letter to the physician requesting copies of the patient's medical records. Enclosed with the letter was an authorization to release the records. The physician did not respond to the attorney's letter, but instead contacted his medical liability insurer and informed it of the letter and authorization. The insurer told the physician to submit the patient's records to the company for its review, and the physician complied with the request. The insurer used the records only to investigate and evaluate the patient's potential malpractice claim against the physician. The records were not disclosed to anyone outside the company.

The patient later sued both the physician and the insurer for breach of confidentiality. In granting summary judgment for the patient, the trial court rejected defendant's contention that the authorization constituted a waiver of the patient s confidentiality rights. The trial court also rejected the contention that disclosure of the records was justified by the notice and cooperation terms of the insurance policy. Finally, the trial court rejected the physician's claim that the disclosure was justified because it was obvious that the patient was going to sue him. The court characterized the physician's belief that a suit was imminent as "mere speculation" and "conjecture".

In reversing, the appellate court ruled that the physician's disclosure of his patient's medical records to the insurer, and the insurer's solicitation of such disclosure, were justified responses to the patient's authorization of disclosure of those records to his attorney. Noting that a patient's right of confidentiality is not absolute, the court explained that the legal and economic interests of a physician and his liability insurer justified disclosure of a patient's medical records where the physician has a reasonable belief that the patient will make a medical malpractice claim against him. The court concluded that the physician's anticipation of a suit was reasonable and was not, as the trial court had found, based on speculation and conjecture. The patient's authorization of the release of his medical records, in the appellate court's view, was an affirmative act from which the physician could infer that a suit would be brought against him. Accordingly, the court ordered that summary judgment be entered for the physician and his insurer.

This case was widely publicized at the time of the lower court ruling and has lead to a good deal of concern on the part of physicians as to whether or not they should comply with their insurer's request for providing medical records on patients short of suit being brought. This has led to a real problem with the doctor being caught between the proverbial rock and hard spot. Most carriers require prompt and full disclosure to the company of any patient care occurrence likely to materialize into a claim or a law suit. Doctors have had understandable concern about how they can best meet the terms of their policy and assist in preparation of their own defense without engendering a suit for breach of confidentiality.

What happened in the New York court, either at the lower level or at the appellate level, is not applicable to Alaska. The issue has not been litigated in Alaska, and there is no law in this state on the topic. Nevertheless, it is reassuring to note the New York appellate court overturning the decision by the lower court.

MICA insured physicians, having any further questions about this issue, are encouraged to call the Claims Manager at MICA for further discussion.

Discoverability Concern

continued from page 1

The Langdon v. Champion decision necessitates a change in our approach to claims management. Upon the report of any occurrence, claim or suit to MICA, the insured may expect to receive a confirmation of notice letter with the name of an attorney who has been assigned to his case. Claims staff will be in immediate contact with defense counsel. An attorney will open a file on the matter in his/her office and consult with claims staff as to needed investigation. That investigation and peer review will continue to be carried out insofar as possible by MICA staff and physician committees, however, it will be undertaken at the direction and request of assigned defense counsel. This will be in fact, as well as in name, since we believe that it would be counter productive to run a sham operation designed to comply with the letter but not the intent of the law.

Needless to say this is going to involve significant added expense.

This is yet another example of the manner in which Supreme Court decisions can radically change the way in which we do business and profoundly impact the cost of doing business.

Policyholders should understand that your company is making every effort to structure its operations to protect the investigation and analysis of reported occurrences, claims and suits. Policyholders remain under the same obligations imposed by their policy and the participatory risk management role is to promptly report occurrences and claims to the company for investigation and management.

Reprinted courtesy of Health Week

Jackson Case Settles

In the previous issues of CLAIMS NEWS, the Alaska Supreme Court decision on Jackson v. Fairbanks Hospital was extensively reported.

The Jackson v. Fairbanks Hospital case is a fairly complex one and the purpose of this article is to trace the history of that case and its ultimate settlement.

Brett Jackson was a 16-year-old boy brought into the Fairbanks Hospital in May of 1981, following a traumatic injury. Jackson was seen in the Emergency Room by Dr. Power who was a physician employed by E.R., Inc., a group of physicians contracting to supply Emergency Room coverage to the hospital. Dr. Power examined the patient and admitted Jackson to the hospital to the service of orthopedic surgeon, George Vrablik, M.D. The admission occurred in the middle of the night and, although there was telephone contact between the Emergency Room physician and the orthopedic surgeon, the orthopedic surgeon was not asked to, and did not, come in to examine Jackson.

Despite obvious trauma to the area over the kidneys, Jackson was not catheterized when he was unable to void. A voided specimen collected four to five hours after admission was grossly bloody and was shown to the Emergency Room physician. The attending physician was not called in. No action was taken until the attending physician arrived at the hospital at 9 a.m., at which time further testing was undertaken and Jackson moved rather rapidly to surgery. Surgery on both kidneys was done by William Montano, M.D. of Fairbanks. One of the kidneys was not salvageable. The other seemed to revascularize, only to succumb to medications given to deal with infection. Jackson had a stormy post-operative course including a pericardial effusion and arrest necessitating the opening of his chest with cardiac massage in his bed.

Jackson ultimately ended up with a kidney transplant which has remained viable for almost three years. He is on high dose steroids and is having signicant demineralization of bones sufficient to necessitate recommendation of a shoulder reconstruction.

Suit was brought in 1984 against the Fairbanks Memorial Hospital and all of the doctors who participated in Jackson's care. Physicians insured by MICA were Dr. Power and the Emergency Room, Inc. group; Dr. Montano and his partner, James Borden, M.D.

During the course of the litigation, plaintiff attorney filed a motion to have the hospital declared liable, as a matter of law, for the actions of the Emergency Room physician. This issue was carried all the way to the Alaska Supreme Court where it resided for several years pending decision. Activity on the basic case was stayed during that period of time.

While awaiting the Alaska Supreme Court's decision, several defendant physicians settled with payment to plaintiffs being made. CNA paid $40,000 on behalf of Dr. Davis and $250,000 on behalf of Dr. Vrablik. James Borden, M.D., insured by MICA, was dropped from the law suit with no payment.

In October of 1987, the Alaska Supreme Court rendered its landmark decision stating that hospitals are liable, as a matter of law, for the actions of Emergency Room Physicians on the basis of nondelegable duty. Following resolution of this issue the basic case proceeded with trial scheduled for May 2, 1988. During the four years between filing of the law suit and the date set for trial, MICA had launched an intense effort to find a medical expert supportive of the decisions made by our Emergency Room physician. We were unable to find a medical expert to support our insured.

Because three years had been lost between the date of this occurrence and the filing of suit and because several years had been lost while awaiting the Supreme Court decision on the liability issue, the case involved significant exposure for prejudgment interest. Prior to the tort reform act of 1986, prejudgment interest accrued at 10.5 percent per annum from the date of occurrence to the date of payment of a judgment. Consequently, we were looking at prejudgment interest in excess of 70 percent being added on to a jury verdict. An additional 10 percent court-awarded plaintiff attorney fees brought the total anticipated add-ons to any jury verdict to approximately 85 percent. In other words, a jury verdict of one million, with prejudgment interest and Rule 82 attorney fees added on, would result in a $1,850,000 judgment.

Brett Jackson's past medical expenses were approaching a half million dollars with a substantial portion of them being paid from federal sources arguably not subject to Alaska's collateral source provision. The remainder of his medical bills were paid from state funded sources but Jackson had committed himself to repay those.

The assessment of the remaining defendants was that there was an overwhelming prospect of a plaintiff verdict. It was felt that a verdict of less than $1.5 million was improbable and a verdict of $5 million or more was not impossible. Considering the potential doubling of the verdict due to prejudgment interest, the prospect of proceeding to trial with no medical experts supportive of care provided by the Emergency Room physician was not palatable for either the ER doctor or the hospital now legally liable for his actions.

The Emergency Room physician, Dr. Power, had very understandable and realistic concerns about a verdict in excess of his policy limits. Despite the hospital being legally responsible for his actions he continued to have individual responsibility. He continued to be a named defendant in the law suit. Even if he had been dropped on the eve of the trial the hospital would have had a common law right of indemnification against him and a statutory right of contribution. The hospital attorney was threatening to assert both of those rights in the event that Power was dropped from the litigation.

Settlement was achieved the week prior to the commencement of trial. Three defendants remained in the law suit at that time: Fairbanks Memorial Hospital and Lutheran Hospitals and Homes Society; Emergency Room, Inc., Jack Power, M.D.; and William Montano, M.D. MICA would agree to no contribution to this settlement on behalf of Dr. Montano whose care was judged to be totally defensible. The entire case was settled with payment of $3.4 million which was divided between the hospital and Dr. Power respectively, $1.6 and $1.8 million. As indicated, $290,000 had already been paid by other carriers insuring other defendant physicians involved in the case.

Settlement monies were divided into up-front cash and purchase of an annuity for Jackson. Plaintiff attorney fees amounted to 40 percent of the total recovery.

Claims News is a publication of MICA's Claims Department. Janet Johnston, Manager. Information contained in this newsletter was obtained from reliable sources, but accuracy cannot be absolutely guaranteed. It is not intended as legal advice. A qualified attorney should be contacted when seeking legal advice.

MICA CLAIM HOTLINE

561-LOSS

Please use this direct line to report a claim, suit or occurrence.

Justice vs. Humana Case Settled

In the last CLAIMS NEWS issue the Justice vs. Humana Hospital case was reported in some detail. At press time the case had gone to trial and the jury had returned a verdict of $1,304,244 against the defendant hospital. The judge had not rendered a judgment. The judgment is the final monetary figure arrived at by the judge taking the jury verdict and adding on such things as pre-judgment interest and court-appointed plaintiff attorney fees (Rule 82 attorney fees) and subtracting things such as payments that fall under the collateral source provision of the law.

ENTRY OF JUDGMENT

Attorneys for both sides submitted voluminous briefs to the court, arguing the add-ons and off-sets that should be applied to the jury verdict. The suggested judgment range was spread from $300,000 to $2,500,000.

Plaintiffs brought heavy pressure on the defendant hospital and its insurer to settle the case prior to entry of judgment. A written settlement offer of $1,850,000 was made on February 11, 1988. Humana Hospital's corporate headquarters in Louisville, Kentucky made a written demand on MICA to effect settlement within the terms of the plaintiff's demand letter. They further charged MICA with the responsibility of indemnifying Humana for any dollar amounts in excess of their $2 million policy in the event that MICA failed to comply with their instructions to settle.

MICA's Board and claims manager declined to settle the case prior to entry of judgment. The lowest written settlement offer received from plaintiffs was $1,750,000.00.

Judgment was entered on March 18, 1988, in the amount of $1,859,518.90, Judge Gonzales having leaned toward plaintiff's analysis of the add-ons and off-sets in preference to the defendant's.

SETTLE OR APPEAL?

From the time of the jury verdict through entry of judgement, discussion continued as to whether the case should be appealed or settled, either by payment of the judgment amount or some other negotiated figure. The defendant hospital, MICA and the medical community in general were appalled at the outcon. of the trial and felt there was reason to appeal. Supporters of tort reform understandably felt this was a textbook case demonstrating the need for reform and that an appeal would be useful to further publicize that issue.

While there was general agreement that the verdict was a disaster, there was a difference of opinion as to whether or not to appeal. Initially there was a great deal of sentiment on the MICA Board that the case should be appealed. The judgment as entered, however, came very close to the hospital's policy limits. An appeal was expected to take several years during which time post-judgment interest at 10.5 percent annually would accumulate. Additionally, the legal cost of taking an appeal plus the cost of the supercedeas bond required during the appeal would have exceeded the hospital's policy limits. Humana's corporate headquarters in Kentucky reiterated the demand that the case be settled within policy limits. There was considerable and prolonged discussion on the MICA Board as to whether or not MICA, given its fiduciary responsibility to all of its policyholders, could ignore Humana Hospital's demand that settlement be made within their $2 million policy limit, thereby making MICA financially responsible for the outcome. It was the eventual conclusion of the majority of the Board that it was our contractual obligation to respect the wishes of our policyholder. Further, the majority of the Board concluded that it was inappropriate to spend policyholder dollars in pursuing an appeal in defiance of our insured's wishes because it fit in with a political agenda.

Concurrent with prolonged discussions over whether or not the case should be appealed, continuing settlement negotiations went on. Eventually, the case was settled for a combination of up-front cash and money to purchase an annuity for the plaintiff. The total settlement amount was less than the judgment entered by the court.

HUMANA FOREGOES INDEMNITY CLAIM AGAINST PHYSICIANS

As indicated in the previous issue of CLAIMS NEWS, plaintiff had dropped the defendant physicians on the eve of trial and pursued the hospital alone. The Humana Hospital had a right of indemnification against the physicians. On March 29, 1988, Humana's corporate headquarters informed MICA that they had decided not to pursue the codefendant physicians in this case for either indemnity or contribution.

MICA Medical Indemnity Corporation of Alaska

Aleut Plaza, Suite 203
4000 Old Seward Highway
Anchorage, Alaska 99503

Risk Management News

MICA
Medical Indemnity Corporation of Alaska

July 1988

GAO REPORT: A FRAMEWORK FOR ACTION

In the fall of 1987, MICA summarized a recent study done by the United States General Accounting Office (GAO), the investigative arm of congress. The GAO had conducted a major review of the medical malpractice situation in the United States. No objective statistical data had been available since 1980, when the National Association of Insurance Commissioners collected and published a similar study.

What risk management lessons can be learned from the study? GAO concluded that reform of state court law, reasonable insurance regulation, better self policing and risk management by health care providers, and consumer education must be part of efforts to resolve the problem.

Appropriate tort reforms would include caps on noneconomic damages, shortening statutes of limitations for filing claims, revising joint and several liability laws, and allowing periodic rather than lump sum payments for large damage rewards.

The report called for more aggressive action against incompetent physicians, better peer review, and thorough hospital based risk management programs. Specific recommendations included enactment of HR1444 and S.661. These bills would prevent physicians who violate Medicare or Medicaid laws or who have had their licenses revoked from participation in either program. Another recommendation included requiring physicians to participate in risk management programs for state licensure.

The GAO study further suggested that the insurance industry's role in alleviating the malpractice liability problem is to maintain appropriate reserves and adhere to sound investment practices. The report indicated that state regulatory departments must ensure that insurance rates are not discriminatory or excessive.

Finally the GAO recommended that the public must be educated as to what to realistically expect from the health care system. Physician/patient communication must be improved to achieve better patient understanding and more reasonable expectations of medical professionals. Included in that would be the physician's need to fully communicate to patients the potential risks associated with the medical treatment.

CLAIMS "HOTLINE"

As of May 5, 1988 MICA will have a Claims "Hotline". The number for that "hotline" will be 561-LOSS (561-5677).

This number will be only for the reporting of incidents or potential claims.

P.R.M.P. ALERT

TO: Mica Insureds
FROM: Art Stanford
Underwriting Manager

MICA's Participatory Risk Management Program, if it is to be effective, must also be adhered to by mid-level practitioners in your employ or those under your supervision.

An example of this failure was a recent and very serious occurrence which was reported to MICA not by the mid-level practitioner most directly involved in the patient's care nor by his supervising physician, but rather by another medical provider subsequently involved in the ongoing care.

This lack of prompt notice of an occurrence, clearly within the reporting perimeters of P.R.M.P., was a serious violation of its criteria and a result of the mid-level practitioners total unawareness of the P.R.M.P. which had never been transmitted to him by his supervising physician.

We cannot over emphasize the need to share the P.R.M.P. with any mid-level practitioner whom you employ or for whom you are otherwise responsible and the need for them to immediately report an occurrence which qualifies under the P.R.M.P. criteria directly to you (for further transmittal to MICA) or directly to the company if you are unavailable.

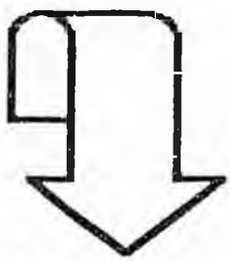
We expect strict adherence to the P.R.M.P. occurrence reporting requirements by those under your supervision and violations by them

will be considered noncompliance by the supervising physician.

MICA will be sending a notice in the near future to all its policyholders reminding them of the need to share the P.R.M.P. with their medical staff or those they supervise and the absolute necessity for complying with occurrence reporting along with the other criteria, depending upon the scope of the mid-level practitioner's responsibilities.

CONFIDENTIALITY

A paper shredder in the office ensures that records, files, and correspondence are disposed of and confidentiality maintained.



SELF ASSESSMENT TEST

Do your office procedures include a mechanism for follow-up when a patient misses an appointment? _____yes _____no

Do you, as a consultant, always contact the referring physician to discuss your findings regarding his/her patient? _____yes _____no

When you refer a patient to another physician do you ever verify that the patient was indeed seen by the consultant and determine the results of that consultation? _____yes _____no

If you order tests on an office patient, do you or your staff follow-up to confirm that the tests were performed and that the test results were communicated to you, entered into the patient's chart, and related to the patient? _____yes _____no

If you answered "no" to any of the above, it's time to establish and implement routine office procedures in this regard.

FOLLOW-UP SYSTEMS

You may wonder where the patient's responsibility lies in returning for follow-up. In general, court decisions have held it is the health care professional's responsibility to make an attempt to contact and encourage the patient to return for needed follow-up. It is felt that the health care professional appreciates the "seriousness" more than the patient.

A "failure to diagnose" claim can be one of the most serious types of malpractice cases today. Many of these cases results in a detrimental delay in following the patient. Often times the doctor is totally unaware that the patient failed to return, as requested, so months elapse and the condition worsens.

A good example of this type of case is a woman who presents with a lump in her breast. A mammogram is ordered and she is told to return prn. The problem is one woman in several hundred will return in a few months with a cancer in the same location or nearby.

A follow-up procedure must be developed by the physician and his/her office staff to ensure that all diagnostic test results are seen by the physician upon receipt in the office. Malpractice actions have often resulted after a lab or x-ray report was filed in the patient's chart but was never reviewed by the physician through some oversight on the part of the physician or staff.

If a doctor can show some chart documentation that attempts were made to contact the patient to return for follow-up, then this documentation provides a better defense. It can help prove contributory negligence on the patient's part.

Patients are sometimes charged with "contributory negligence" when the jury feels that the patient contributed to some degree in the damage. Awards may then be reduced by the amount or percentage the jury felt the patient was responsible.

When a patient misses an appointment it is very good practice to have an established mechanism whereby office staff attempts to contact the patient.

Generally, follow-up attempts include one phone call and if that is not successful, then a post card or letter should be sent. These attempts should be documented in the record, even if the phone call(s) went unanswered and the patient was never reached. If the condition is serious, i.e., following a potential cancer patient, you may want to send a certified letter with return receipt requested. This receipt is filed in the chart with a copy of the letter for documentation.

The area of follow-up most frequently missed is follow-up to ensure that the patient sought consultation.

A referring physician has a responsibility to see that the consultation did indeed occur and to obtain results of that consultation. The referring physician has a responsibility to inform the patient of those results and to act upon the information derived from the consultation. All aspects of the consultation process must be documented in the patient's chart.

The conusltant also has the responsibility to communicate the results of his/her consultation to the referring physician. Follow-up is especially important when a consultation is deemed necessary because of a suspected cancer. There have been cases where a breakdown in the consultation process led to serious problems for the patient and ultimately, for the involved physicians when litigation resulted.

When considering the potentially grave consequences of an inadequate follow-up system, it helps to keep in mind what tack, even a novice lawyer, would follow in presenting a malpractice claim against you for an adverse outcome directly attributed to the lack of follow-up. The attorney's questions might inlcude:

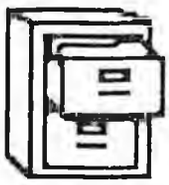
"Doctor, don't you receive regular periodic notices from your dentist (just for innocuous check-up) and possibly even from the veterinarian for your pet's annual innoculations"? It doesn't take much imagination to visualize the attorney's next question.

LOSS PREVENTION
563-3414

MICA is organized to give insureds optimal support in addressing unexpected situations. If you enounter unusual or questionable circumstances during a course of patient treatment, please report this promptly to MICA. We can help.

Penny Chmielewski, R.N.,
Risk Management Coordinator

Janet Johnston
Claims Manager



TICKLER FILE

Many computer programs have excellent recall and follow-up capabilities. If your office is not computerized it is fairly simple to develop a manual system.

1. Obtain a 3 x 5 card file with monthly dividers; i.e., January through December.

2. When a patient needs to return for a follow-up condition a card is filled out with the following information:
   - patient's name
   - patient's file number
   - telephone number
   - address
   - reason patient needs to return (i.e. pap smear, check up, etc.)
   - month and year the follow-up is due

This system can also be used to follow-up on patients referred for outside consultation.

3. Place this card in the file box in the month the patient needs to return.

4. There are two ways to complete the process:

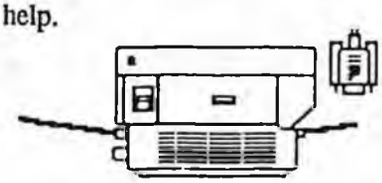
   • Pre-Contact:

If you wish to reach the patient prior to the due date, then pull all the cards in the month before the patients are due for a return visit. Call or send a reminder card/letter to them. It is important to keep the cards until the end of the month that the patients were supposed to return. You need to check these at the end of the month and notify those patients who failed to keep their appointment.

   • Post-Check

You may wish to eliminate the double check system and simply pull all the cards at the end of the month and check the chart to verify the patient did return for follow-up. The patient who did not return for follow-up will then be notified.

If you have any questions regarding developing follow-up systems, please contact the MICA Risk Management Department for further help.



EQUIPMENT MALFUNCTION PRECAUTIONS

Defined procedures, clear communication and system routines in a medical office are everyone's responsibility. The office staff can make a vital contribution to achieving a pleasant, effecient, office where very few mistakes occur and preventable errors are eliminated. The reward is that everyone benefits; the patient, the physician and the staff.

Most equipment-related suits involve electric burns. The following guidelines can be used to make using office equipment safer:

- Be sure to check all electrical equipment to be sure that it is properly gounded.
- A staff member needs to be assigned responsibility for assuring that new personnel are instructed in the correct use of office equipment.
- The initial utilization of the equipment needs to be supervised by an experienced person.
- Immediately stop using defective equipment.
- Report all equipment malfunctions of a significant nature to the appropriate person in the office.
- Resume using the equipment, only after it is repaired.

TO: MICA Insureds
FROM: Mary Pierce
Executive Director

Over the past few months we have been receiving confidential documents (medical records and incident reports) sent to our Post Office Box. This box is at our bank data processing center, used for the purpose of automatic deposit for all premium payments received and it should only be used for the submission of premium payments. All mail received at this box is opened and then forwarded to us.

In an effort to protect the confidentiality of all sensitive documents sent to MICA, we are requesting all mail other than premium payments be sent to our office location, 4000 Old Seward Highway, Suite 203, Anchorage, Alaska 99503.

Thank you very much for your assistance in this matter.

Risk Management News is a publication of MICA's Risk Management Department, Penne Chmielewski, Coordinator. **Information contained in this newsletter was obtained from reliable sources, but accuracy cannot be absolutely guaranteed. It is not intended as legal advice. A qualified attorney should be contacted when seeking legal advice.**

MICA Medical Indemnity Corporation of Alaska
Aleut Plaza, Suite 203
4000 Old Seward Highway
Anchorage, Alaska 99503

Risk Management News

MICA Medical Indemnity Corporation of Alaska

August 1988

TO: ALL MICA INSUREDS

Pediatricians, Obstetricians, Family Practitioners, General Practitioners, Neonatologists, Neurologists, Neurosurgeons, General Surgeons

"**THE SCENE:** A newborn has just arrived! Immediately prior to the delivery or C-section there was evidence of fetal distress! The newborn has low APGARS and is not rapidly recovering"!

"Inevitably, a progress note will mention "hypoxia, 'birth trauma' or another term suggesting that an otherwise normal fetus has recently suffered damage. Such notes suggest to those later evaluating a potential medical liability claim that someone may have made an error during labor and delivery which caused the resultant brain damage.

There is increasing evidence that placental abnormalities occuring much earlier in pregnancy may be the cause of many or most brain damaged newborns. The mechanism of this is not totally clear at this point. In the mean-time, however, it might be well to refer to the evidence of newborn damage in progress notes and leave out words which suggest the etiology of that damage. It is becoming increasingly clear that the time honored concept of a normal term fetus suffering central nervous system damage as a result of an event during labor and delivery may be far less frequent than previously thought. Indeed, it is possible that most, if not all, such damage is predestined by a pre-existing placental condition. To suggest by words such as 'hypoxia' or 'brain damage' that damage occurred solely because of the events of labor and delivery is possibly a major disservice to all involved".

Reprinted, with permission, in its entirety from COPISCOPE, Issue #18, May 1987, Published by Colorado Physicians Insur. Co.

MICA encourages accurate notes. In light of this report, some added thought or diagnostic work may result in more accurate reports.

MICA recommends obtaining a cord PH at the time of delivery for all neonates who demostrate signs of fetal distress.

PARACERVICAL BLOCK ANESTHESIA PRESENTS RISKS

Paracervical block for regional anesthesia, during first stage labor, continues to be controversial. Though used in only 5% of births, there is a concomitant 25% increase of fetal bradycardia attributed to this method. Often transient bradycardia can persist, resulting in untoward complications and death to the fetus.

Settlements against physicians involved in these cases have been substantial. The following California case illustrates the potential liability and outcome.

CASE

During an otherwise uneventful course of labor the patient, a 31 year old primagavida, requested and received minimal anesthesia via a paracervical block. This mother had anticipated a natural childbirth, with little or no need for anesthesia. A paracervical block was chosen, by mutual agreement, from a number of options described by the physician just prior to admission. None of the risks for any type of anesthesia were presented to the patient.

Internal fetal monitoring, that had demonstrated good variability and accelerations, changed within four minutes of the administration of 12 ccs. of Bupivacaine (Marcaine) .25% use for the paracervical block.

The fetal heart rate dropped from 140-160 to 90 beats per minute with a loss of beat-to-beat variability. Within the next minute the rate declined further, to 60 beats per minute, where it remained. Little, if any, anesthetic effect was reported by the mother.

An oxytocin drip was discontinued.

The mother was turned on her left side and 100% oxygen was administered with the goal of inhibiting further contractions and enhancing maternal-fetal blood exchange. An emergency Caesarean Section was considered contraindicated by the physician. He supported this inaction with the theory that maximal clearance of any toxic effect is best accomplished in utero, via the placenta. Accordingly, he waited 40 minutes. The fetal heart rate remained at 60 beats per minute then ceased, 60 minutes from the time Marcaine was administered. The stillborn infant was delivered vaginally.

The cord blood specimen demonstrated high, potentially toxic, levels of Marcaine in the fetal circulation. It was hypothesized that transplacental uptake had occurred via maternal, paracervical vessels that were entered during the administration of the anesthetic.

The case was settled against the defendant physician with a substantial award to the plaintiff.

GUIDELINES

The following guidelines are recommended to physicians who continue to administer paracervical blocks.

1. Obtain informed consent before administering any anesthesia. Include a discussion of risks involved for both the mother and the baby. Specifically mention the potential for complications and the alternatives for anesthesia and vaginal delivery. When recording your decision, document your decision with the patient and the father, if he is present.

2. Do not routinely administer a paracervical block for pain during the first stage of labor. Evaluate each patient, her response to pain, and the progression of labor on an individual basis.

3. Consider employing alternative modalities of analgesia/anesthesia exclusive of paracervical blocks. This modality is definitely contraindicated when there is uteroplacental insufficiency, evidence of pre-existing fetal distress or prematurity. Judicious use of narcotic analgesia is a suitable alternative.

4. If a paracervical block is to be administered, do not use Bupivavaine (Marcaine or Sensorcaine). It is not recommended for obstetrical anesthesia by the manufacturer. Xylocaine or Mepericaine are suitable agents. If used, these agents should not contain Epinepherine.

To summarize, paracervical block continues to decline as a recognized method of choice for obstetrical anesthesia. If a paracervical block is administered, the physician must anticipate the potential complications and be prepared to manage them. The decision to employ this technique carries a responsibility to consider potential hazards to the fetus.

These risks must be communicated and documented when you obtain informed consent. Alternatives must be considered. If a paracervical block is administered, your technique must follow recognized standards, including the correct use of approved agents.

OBSTETRICS AND FAMILY PRACTICE

Pregnant women and their families may be uniquely angry if their physician is unavailable for the delivery. Physicians usually explain to all patients that since delivery can not be scheduled, their doctor may be unavailable. However it may be helpful to not only explain this to all OB patients but to have them complete a form such as the following;

"In order to assure quality care for you at all times, Dr._____ is directly associated with three other physicians, Dr._____, Dr. _____, and Dr. _____.

Dr. _____ will care for you through your pregnancy, and in most cases will be with you for your delivery. However if you were to deliver in his absence, one of the other physicians will assume responsibility for your care.

We want our patients to be happy with this arrangement and if you have any questions, please feel free to discuss them with us."

*Patient*_____
*Father of the baby*_____
*Date*_____

MICA suggests that this would help decrease anger in a patient, especially the husband, when the regular Obstetrician or Family Practitioner is away and another physician delivers the baby.

HOSPITAL RISK CONTROL OBSTETRICS

Medical Records
Does the medical record include:

- **prenatal information?**
- **time that patient arrived at hospital?**
- **time that obstetrician responded?**
- **time of last meal?**
- **discharge summary?**
- **fetal strips?**
- **evidence of informed consent?**
- **reasons for cesarean delivery?**

Are medical record audits performed?

ADVICE ON AFP TESTING

Neural tube defects (NTDs) are among the most commonly occuring major congenital malformations with an incidence of 1 to 2 per 1,000 live births in the United States.

Alpha-Fetoprotein (AFP) is a protein produced by the fetus which is transferred in small amounts across the placenta into the mother's blood stream. The amount of AFP in the mother's blood can be measured and compared with the amount normally expected for a given week of pregnancy.

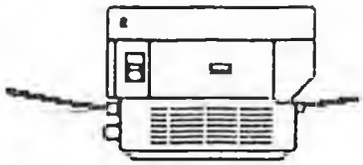
In early pregnancy maternal serum AFP is low but rises rapidly to a peak value at about 30 weeks' gestation. In the second trimester the level of fetal serum AFP is approximately 100 times that of maternal serum AFP.

The level of AFP is elevated in pregnancies when the fetus has a neural tube defect. However it should be noted that incorrect assessment of gestational age may create false high (or low) levels, particularly of maternal serum AFP, because the rapidly changing range of normal AFP values depends so critically upon gestational age.

Some states, such as California, have a mandatory AFP screening program. All prenatal care providers are required by law to provide all pregnant women with information about AFP screening and the opportunity to participate in the program. Patient participation is strictly voluntary. The duty to inform and obtain written consent or refusal is mandatory for physicians providing prenatal care anytime through the nineteenth week of gestational age.

The MICA Risk Management Subcommittee on Obstetrics reviewed the various AFP programs and the ACOG recommended guidelines "Prenatal Detection of Neural Tube Defects". They concluded that the "standard of care" in Alaska at this time supports informing pregnant women about the availability of AFP testing. Although the value and implications of this test continue to be debated, MICA recognizes the areas of potential liability risk and advises the following:

- Obtain, review and integrate into your practice, educational materials that are available for AFP testing.
- For patients receiving prenatal care before the 20th week of gestational age, obtain a signed consent or refusal to have the patient participate in the AFP testing. Retain this document in the patient's medical record.
- For patients electing to have AFP testing, a careful and sensitive approach to counseling must be observed. Document your discussions, the patient's response and plans.
- Recognize the importance of using the most reliable and appropriate methods for dating gestational age; that both false negative and false positive blood test results can arise from incorrect dating.
- Follow-up on all patient's questions and test results.



HOSPITAL RISK CONTROL ELECTRONIC FETAL MONITORING

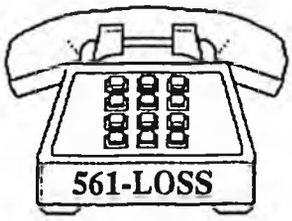
The most common known hazard of EFM is infection. In the fetus, this is usually a minor scalp infection or abscess caused by the scalp electrode. In the mother, EFM related infection is difficult to separate from infection related to C-Sections. Less frequent complications are caused by errors in applying the fetal scalp electrode and intrauterine pressure catheter.

In a joint statement ACOG and the Nurses Association of the ACOG (NAACOG) stated that "it is the responsibility of the hospital to verify the knowledge base of health professionals in the clinical application of electronic fetal monitoring and to encourage continuous updating of their skills."

ALPHA FETO PROTEIN

POTENTIAL FALSE RESULTS

AFP RESULT	POSSIBLE REASON	POTENTIAL OUTCOME
False negative (NTD present)	Actual gestational age younger than estimated.	Neural tube defect not diagnosed.
False positive (NTD not present)	Actual gestational age older than estimated.	Unnecessary anxiety for the patient until retested.



CLAIMS "HOTLINE"

As of May 5, 1988 MICA has a Claims "Hotline". The number for that "hotline" is 561-LOSS (561-5677).

This number is only for the reporting of incidents or potential claims.

Risk Management News is a publication of MICA's Risk Management Department, Penne Chmielewski, RN, Coordinator. Information contained in this newsletter was obtained from reliable sources, but accuracy cannot he absolutely guaranteed. It is not intended as legal advice. A qualified attorney should be contacted when seeking legal advice.

MICA Medical Indemnity Corporation of Alaska
Aleut Plaza, Suite 203
4000 Old Seward Highway
Anchorage, Alaska 99503

BULK RATE
U.S. POSTAGE
PAID
PERMIT NO. 155
ANCHORAGE, AK

PARTICIPATORY RISK MANAGEMENT PROGRAM

MICA Medical Indemnity Corporation of Alaska

4000 Old Seward Highway • Anchorage, Alaska 99503 • (907) 563-3413

PARTICIPATORY RISK MANAGEMENT CRITERIA #1

OCCURRENCE REPORTING

OCCURRENCE REPORTING — EXPLANATION

The value of early OCCURRENCE REPORTING can be clearly demonstrated in the claims files of MICA and other medical liability insurance companies. OCCURRENCE REPORTING is one way in which individual physicians and hospitals can favorably impact liability insurance premiums. MICA has emphasized early OCCURRENCE REPORTING in all of its risk management programs for the past 2 years.

The MICA policy language has always required it (see section entitled Insured's Duty in the Event of an Occurrence, Claim or Suit).

Despite these efforts, many occurrences now reported:

1. are not reported until an attorney requests records or a suit is filed (usually many months or years after the event).

2. are events that should be unequivocally reported at the time of the occurrence and are not.

It is unfair that the real or potential savings generated by those who report early should be shared by those who don't or won't. Following the initiation of the Participatory Risk Management Program (PRMP) on 1/1/87, MICA will expect an occurrence report within a reasonable time after the event is known or should have been known by the physician or hospital. Usually this will be within 24 to 72 hours. Telephone notice must be followed by written notice. MICA may choose to accept extenuating circumstances for delays beyond this prescribed time interval.

When an occurrence is reported in writing, MICA will mail a verification form to the reporting physician or hospital. MICA will consider that an occurrence has been reported when any MICA insured physician or hospital caring for the patient has submitted written notice and received verification. However, it is anticipated that the physician primarily responsible for that aspect of the patient's care related to the occurrence will report. OCCURRENCE REPORTS can be made to either the Claims Department or Risk Management Department of MICA.

Misconceptions about OCCURRENCE REPORTING

Many hospitals and physicians have fallacious beliefs about MICA's position on OCCURRENCE REPORTING. These include:

1. "I will be penalized for reporting occurrences." Not true! You may indeed be penalized for the facts of the case, but never for the act of OCCURRENCE REPORTING. As a matter of fact, a penalty will be assessed for failure to report.

2. "I don't know what to report." The criteria for reporting have been presented. If in doubt, call and discuss the issue with MICA's Risk Management or Claims Department. It is clearly not necessary to report each and every expected and/or minor complication.

3. "Increased reporting will raise premiums." Not true! Premiums are now higher to some extent because MICA and its reinsurers know, from past experience, that there are many unreported occurrences which will eventually become claims.

4. "There's nothing that MICA can do to help prevent a suit or keep losses down." Not true! MICA's Claims and Risk Management departments can be helpful in reducing the risk of suit and preventing excessive losses.

5. "If I report an occurrence MICA will try to contact the patient, their family or an attorney." Not true! If this is an occurrence report and there has been no attorney involvement, MICA will make no contact or decision without your concurrence.

6. "I don't think they'll sue me." On occasion this may be true. Certainly the patient/physician relationship is a prime way to prevent medical liability actions. However, never assume this. Report occurrences regardless of your feelings about your relationship with the patient.

OCCURRENCE REPORTING — CRITERIA

MICA will use the following criteria as the standard by which it will judge the adequacy of OCCURRENCE REPORTING for occurrences after 1/1/87.

1. Some litigation cannot be anticipated. On these occasions MICA will expect an occurrence report:

   a. When suit papers, notice of suit or notice of intention to sue becomes known to the insured.

   b. When the insured knows of an attorney request for information or records. Exception: in a Workman's Compensation or automobile accident case where the patient did not substantially deteriorate while under care.

2. MICA will expect an OCCURRENCE REPORT for every negligent act which adversely affects the patient. For example:

   a. Unanticipated foreign bodies left within the patient.

   b. Wrong medication or wrong dosage with adverse sequelae.

   c. Operation on wrong side or at wrong level.

3. MICA will expect an OCCURRENCE REPORT for every major unexpected injury occurring to a patient under your care and resulting from any aspect of that care. The words "major" and "unexpected" are, to some degree, vague and open to interpretation. The list below is not meant to be complete or exhaustive, but is meant to portray the type of event for which MICA expects an OCCURRENCE REPORT.

   a. Any major unanticipated fetal damage. For example: brain damage, major injury or death.

   b. Any unanticipated death. This is not meant to include cases where the medical record reflects that death is a likely possibility of the patient's disease or the medical or surgical care.

c. An unanticipated major surgical complication. For example: brain damage, quadriplegia, paraplegia, incontinence, organ perforation, nerve injury, blindness, deafness, loss of an extremity, death, etc. This is not meant to include relatively minor expected surgical complications such as wound infection, dehiscence, phlebitis, urinary tract infection, etc., unless these conditions continue to major unexpected disability.

d. Failure to diagnose. This category is expected to include those occasions when the physician had a clear opportunity to diagnose a serious condition, but didn't and later learns that the condition existed. For example, breast carcinoma, other carcinoma, meningitis, surgical abdomen, fracture, myocardial infarction, intracranial hematoma, obviously missed radiological or pathological diagnosis, etc.

e. Fall in hospital or office which results in injury that extends patient disability and/or requires significant additional care thus increasing the bill.

PARTICIPATORY RISK MANAGEMENT CRITERIA #2

CONSENT FORMS

CONSENT FORMS — EXPLANATION

The doctrine of INFORMED CONSENT is generally understood by most physicians. In the simplest terms it affirms that the patient has the sole authority to determine what medical treatment, if any, he or she will allow to be performed upon his/her body. Exceptions to this self-determination usually include minors, life-threatening emergencies and incompetency.

INFORMED CONSENT is, by its very nature, verbal (perhaps supplemented with pictures), interpersonal, private and specific. In most cases, the exact nature of what transpired will never be known except to the participants. However, medical liability claims frequently require that the essence of what was said and understood be provable at a later date. Hence, the absolute need for a suitable CONSENT FORM.

MICA will require an acceptable CONSENT FORM in all elective surgical procedures and certain other invasive procedures to be documented. However, MICA recommends evidence of CONSENT whenever there is substantial risk included in the proposed therapy or procedure. MICA will provide a standard form, assist in generating specific forms, and answer questions regarding INFORMED CONSENT and CONSENT FORMS.

CONSENT FORMS — CRITERIA

For any future claims involving an occurrence date after 1/1/87 MICA will consider a CONSENT FORM acceptable under the PRMP only if it:

1. is consummated when the patient consents. The "night before surgery (procedure)" would only be acceptable if the facts clearly demonstrate that the decision was made then or the person performing the procedure became involved then;

2. is dated;

3. is written in language generally understandable by a lay person;

4. is signed by the patient (or other appropriate party) immediately after a short paragraph stating that an explanation has been given, that their questions have been answered and they wish to proceed;

5. is signed by the physician immediately after a short paragraph which states that the physician has explained, answered questions, and believes that the patient understands and wishes to proceed;

6. contains reference to a few general complications that may occur with any procedure (e.g. infection, bleeding, nerve injury, blood clots, pneumonia, etc.);

7. contains reference to the specific/serious complications that may occur with this operation. This requirement may be in the form of a blank on a standard form which is filled in by the physician at the time consent is requested. Examples of specific complications for operations are:

   a. Paralysis after spinal surgery;
   b. Brain damage after brain surgery;
   c. Blindness after eye surgery;

d. Deafness after ear surgery;
e. Perforation with bowel injury after D & C abortion;
f. Perforation after endoscopy;
g. Bile duct injury after gallbladder surgery;
h. Voice box nerve injury after thyroid surgery;
i. Amputation after lower extremity vascular surgery;
j. Fertility after sterilization procedure;
k. Etc.

To assist the insured physicians in understanding those procedures for which MICA will require an acceptable CONSENT FORM, the following lists have been compiled:

1. Required:

   a. All surgical procedures usually requiring general or regional anesthesia
   b. Any other procedure usually requiring general or regional anesthesia
   c. Cerebral and coronary angiography
   d. Endoscopy
   e. All sterilization procedure
   f. Any procedure where the usual risk is substantially increased because of some aspect of the patient's medical condition
   g. All plastic surgical procedures
   h. All surgical procedures upon the eye
   i. All surgical procedure upon the middle and inner ear
   j. Needle biopsy of internal organs

2. Not mandatory, but recommended, that there be at least a note in the doctor's handwriting about consent. However, CONSENT FORMS, if generated, would be most appreciated for:

   a. Minor procedures generally done under local anesthesia, e.g., skin biopsy
   b. Other contrast material injection
   c. The following drug or drugs with similar problems: Long-term anticoagulation, long-term steroids, antibiotics which damage the eighth nerve, chemotherapeutic agents, drugs commonly known to impact bone marrow adversely (Chloromycetin, Butazolidin, etc.).

PARTICIPATORY RISK MANAGEMENT CRITERIA #3

ALTERED MEDICAL RECORDS

ALTERED MEDICAL RECORDS — EXPLANATION

The medical record is critical to the defense of nearly every medical liability claim. Any portion of the record which appears to have been ALTERED may decrease the effectiveness of that record. ALTERED records may cause the award of punitive damages in addition to compensatory damages. ALTERATIONS of the medical record raise questions about the honesty of the physician and thus may render him/her indefensible regardless of the facts of the case.

CLARIFICATION of the medical record may be necessary. To be acceptable to MICA, a CLARIFICATION shall appear only at the end of the progress notes which existed on the date the CLARIFICATION was made. This CLARIFICATION shall also contain an explanation of why the note was added or changed; be clearly timed and dated; and be signed.

ALTERED MEDICAL RECORDS — CRITERIA

For any future claim with an occurrence date after 1/1/87, MICA shall consider any record to have been ALTERED where the insured or the insured's employee shall have caused:

1. Any change or addition to a medical record when it:

   a. attempts to hide the time the change or addition is made;
   b. attempts to hide the original meaning; or
   c. attempts to change the meaning of the record without an explanation as to why.

2. Any erasure, white-out or obliteration of information.

3. Any writing between lines or in margins except:

   a. spelling corrections,
   b. filling in blanks left by a typist; or
   c. adding a word or phrase inadvertently left out which in no way can be construed as changing the content of the original writing.

PARTICIPATORY RISK MANAGEMENT CRITERIA #4

DIAGNOSIS OF BREAST CARCINOMA— EXPLANATION

Certain patient complaints or findings should cause physicians to consider a diagnosis of carcinoma and to initiate a diagnostic program to substantiate or rule out that diagnosis. Failure to diagnose a carcinoma, which is later proven, may lead to litigation. Theoretically, any patient whose carcinoma is not diagnosed in a timely fashion might initiate a lawsuit. However, MICA and other medical liability insurance carriers see most cases of this type when they involve a failure to diagnose carcinoma of the breast. Probably this failed diagnosis is most commonly litigated because of society's focus upon this disease and because of the frequency with which women "find" breast lumps and report them to their physician.

MICA has identified several situations which repeatedly cause high exposure involving the diagnosis of breast carcinoma.

1. The woman reports a breast concern and the physician determines, based upon clinical examination alone or combined with mammography (or another imaging technique), that it is benign. The patient is told to return p.r.n..

2. The physician conducts a workup for the area of concern with questionable or suspicious results. The patent is told to return p.r.n..

3. A woman of any age is at risk of breast carcinoma. However, the American Cancer Society has identified certain women whose age and/or family history place them in a higher risk group. A woman fitting these criteria is not appropriately studied and followed.

DIAGNOSIS OF BREAST CARCINOMA-- CRITERIA

The records kept by physicians treating patients in the following categories shall document that the indicated treatment was recommended or accomplished. If such studies are refused by the patient, there will be adequate documentation of the fact that she has refused and that she has been fully informed of the reasons for the recommended study and the risk, including death, of non-compliance.

1. All patients with breast complaints shall have a documented breast and lymphatic examination.

2. In those patients with a palpable dominant mass, the nature of the lesion will be determined by aspiration or biopsy unless spontaneous resolution has occurred within a period of 8 weeks.

3. It should be recognized that the role of mammography is only to evaluate the status of breast tissue elsewhere in both breasts and is not to be used to judge whether the mass in question is benign or malignant.

4. Non-palpable lesions demonstrated by mammography or other imaging techniques shall be resolved by biopsy or sequential repeat imaging studies.

5. All patients 40 years of age and older with a family history of breast cancer in close female relations shall have an annual documented breast and lymphatic exam, annual mammogram and documented instruction on breast self-examination. This criteria shall be held for physicians whose charts clearly demonstrate that they are either the patient's primary physician or are regularly following this patient periodically for other female examinations such as PAP smears, pelvic exams, etc.

6. Patients with a personal history of breast cancer shall have an annual documented breast and lymphatic exam, an annual mammogram and documented instruction on breast self-examination. This criteria shall be held for physicians whose charts clearly demonstrate that they are either the patient's primary physician or are regularly following this patient periodically for other female examinations such as PAP smears, pelvic exams, etc.

7. For patients receiving informed consent for total or partial mastectomy, the record shall reflect discussion of alternative methods of treatment.

PARTICIPATORY RISK MANAGEMENT CRITERIA #5

ANESTHESIA MONITORING — EXPLANATION

Although there is a wide spectrum of causes for anesthesia medical liability claims and losses, the devastating results of sudden, unexpected cardio/pulmonary arrest or failure accounts for well in excess of 75% of anesthesia dollar losses. In nearly all of these cases, there is expert testimony that there was a failure to adequately monitor the patient. The allegation of failure to monitor adequately nearly always involves a failure to utilize commonly accepted monitoring techniques: monitors which are not working at the time of the catastrophe; or inattention or lack of vigilance to the monitors.

ANESTHESIA MONITORING — CRITERIA

For any future MICA claim with an occurrence date after 1/1/87, MICA will utilize the following guidelines for assessing adequacy of monitoring:

1. Physical presence: The primary anesthesiologist or nurse anesthetist shall be physically present in the Operating Room at all times during regional and general anesthesia. If required to leave, that person may be replaced by another anesthesiologist or CRNA.

2. Emergency: In the event that an unexpected emergency requires the temporary absence of the person primarily responsible for the anesthetic, it will be expected that the best judgement will be exercised in comparing the emergency with the anesthetized patient's condition and in the selection of the person left responsible for the anesthesia.

3. Monitoring:

   a. General Anesthetic (all cases)

      1. Auditory monitoring of the heartbeat (except for planned asystole) and breath sounds

      2. Intermittent or continuous blood pressure monitoring

      3. Continuous electrocardiographic display

      4. Inspired oxygen monitor (oximeter)

      5. There shall be immediately and readily available a means to measure the patient's temperature

      6. Airway pressure gauge

         (Under extreme extenuating circumstances, the attending anesthesiologist may waive these requirements after stating the reasons for doing so in a note in the patient's chart.)

   b. General Anesthetic (intubated and controlled ventilation)

      1. All of the above, plus

2. Airway disconnect alarm (e.g. pressure disconnect or CO_2 monitor)

   (Under extreme extenuating circumstances, the attending anesthesiologist may waive these requirements after stating the reasons for doing so in a note in the patient's chart.)

c. Major regional anesthesia (e.g. spinal or epidural)

   1. Intermittent or continuous blood pressure monitoring

   2. Continuous electrocardiographic display (during initial injection and establishment of a safe level).

      (Under extreme extenuating circumstances, the attending anesthesiologist may waive these requirements after stating the reasons for doing so in a note in the patient's chart.)

d. Obstetrical (vaginal delivery) regional

   1. Intermittent or continuous blood pressure monitoring

   2. Continuous electrocardiographic display (during initial injection and establishment of a safe level)

      (Under extreme extenuating circumstances, the attending anesthesiologist may waive these requirements after stating the reasons for doing so in a note in the patient's chart.)

e. Minor (single extremity) regional

   1. Intermittent or continuous blood pressure monitoring

   2. Continuous electrocardiographic display (during initial injection).
      EXCEPTION: should be continuous for a Bier block

      (Under extreme extenuating circumstances, the attending anesthesiologist may waive these requirements after stating the reasons for doing so in a note in the patient's chart.)

   3. EXCEPTION: For extremity regional anesthesia, i.e., brachial plexus and lumbosacral plexus block, the patient must be attended and monitored for thirty minutes or until the block is found to be adequate. If additional supplementation is required, the anesthetic will be attended and monitored as any other. In all cases, periodic block pressure determinations, as well as continuous ECG and pulse oximetry with audible alarms, will be employed while in the operating room.

PARTICIPATORY RISK MANAGEMENT CRITERIA #6

OBSTETRICS — EXPLANATION

Obstetrical claims are the singularly most expensive medical malpractice claims of the day. The reasons for this are multiple and include rapidly expanding technology in the field of obstetrics: enhanced patient expectations; the right of the patient to be informed; media education; child birth preparation classes; and an increasing litigious society. Claimant attorneys, ever on the look out for serious injury cases, have taken advantage of the opportunity to sue on behalf of the unfortunate child with neurologic deficits regardless of whether or not the injury, by most objective standards, was the fault of the physician.

As a result, the physician who delivers babies is a primary target, and his insurance carrier has many of its most serious cases in this area.

Recent studies carried out by physician owned insurance companies have revealed that there are several areas of obstetrical care and record keeping that give rise to the preponderance of claims. These include: identification and documentation of high risk pregnancy; problems with identification of gestational age; fetal size and presentation; fetal monitoring; and transfer tissues.

The obstetrical criteria outlined here, if followed and adequately documented, will be of great assistance to the physician in defending himself in an obstetrical malpractice case.

OBSTETRICS — CRITERIA

1. Identification of High Risk Pregnancy

   a. Complete a comprehensive obstetrical form which identifies and documents prenatal risk factors.

   b. Use progress notes to detail the evaluation of risk factors when it cannot be carried out on the standard form.

2. Determination of EDC

   a. EDC should be correlated with menstrual dates, previous use of oral contraceptives, early pregnancy testing, quickening, appearance of fetal heart tones with doppler and fetascope as well as uterine size throughout the pregnancy.

   b. Significant discrepancy between uterine size and these factors should be evaluated with ultrasound.

3. Evaluation of Gestational Age Problem

   a. Evaluate for IUGR when:

      1. There is no apparent uterine growth over a two month time period; or

      2. There is a lack of maternal weight gain in the last two trimesters of a nonobese patient.

5. Fetal Monitoring.

   Continuous electronic fetal monitoring is indicated with labor of all high risk pregnancies (see #1). Documentation of prompt response by the attending physician to an indication of abnormal fetal heart tracings is imperative. Use of fetal monitoring requires expertise in the interpretation by the physician and nursing staff in attendance. If the patient refuses electronic fetal monitoring at any time, that circumstance should be well documented, including the discussion of risk and alternatives with the patient.

6. Transfer Issues.

   When ultrasound is indicated but not available, practitioners in rural areas will inform patient of the role ultrasound could play in evaluating the pregnancy, the options available for obtaining such tests and the risk of refusing such testing, including fetal death or damage. If the patient refuses such tests, the record shall reflect informed patient refusal.

   Transfer to a level 2 or a level 3 perinatal unit should be accomplished on a timely basis with complication or high risk pregnancy. The record shall clearly indicate that the attending physician has fully informed the patient of her potential need for a level of care exceeding that available in the community; the options for obtaining such care; and the risks of refusing transfer including fetal death or damage. In the event the patient refuses transfer, her informed refusal should be well documented.

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

PARTICIPATORY RISK MANAGEMENT CRITERIA #6

OBSTETRICS — EXPLANATION

Obstetrical claims are the singularly most expensive medical malpractice claims of the day. The reasons for this are multiple and include rapidly expanding technology in the field of obstetrics: enhanced patient expectations; the right of the patient to be informed; media education; child birth preparation classes; and an increasing litigious society. Claimant attorneys, ever on the look out for serious injury cases, have taken advantage of the opportunity to sue on behalf of the unfortunate child with neurologic deficits regardless of whether or not the injury, by most objective standards, was the fault of the physician.

As a result, the physician who delivers babies is a primary target, and his insurance carrier has many of its most serious cases in this area.

Recent studies carried out by physician owned insurance companies have revealed that there are several areas of obstetrical care and record keeping that give rise to the preponderance of claims. These include: identification and documentation of high risk pregnancy; problems with identification of gestational age; fetal size and presentation; fetal monitoring; and transfer tissues.

The obstetrical criteria outlined here, if followed and adequately documented, will be of great assistance to the physician in defending himself in an obstetrical malpractice case.

OBSTETRICS — CRITERIA

1. Identification of High Risk Pregnancy

   a. Complete a comprehensive obstetrical form which identifies and documents prenatal risk factors.

   b. Use progress notes to detail the evaluation of risk factors when it cannot be carried out on the standard form.

2. Determination of EDC

   a. EDC should be correlated with menstrual dates, previous use of oral contraceptives, early pregnancy testing, quickening, appearance of fetal heart tones with doppler and fetascope as well as uterine size throughout the pregnancy.

   b. Significant discrepancy between uterine size and these factors should be evaluated with ultrasound.

3. Evaluation of Gestational Age Problem

   a. Evaluate for IUGR when:

      1. There is no apparent uterine growth over a two month time period; or

      2. There is a lack of maternal weight gain in the last two trimesters of a nonobese patient.

b. The evaluation of suspected IUGR will consist of:

1. Serial ultrasounds; and

2. O. B. Consultation: When ultrasound shows evidence of IUGR, the practitioners will be expected to arrange for the patient to be seen by an obstetrician for consultation. Non-Ob/Gyn practitioners in rural areas with no obstetrician available will consult by telephone and document the advice received in the medical record.

c. Appropriate evaluation of post date pregnancy should include:

1. Twice weekly nonstress testing (with the addition of contraction stress testing when the NST is inconclusive), and weekly ultrasound starting by two weeks past EDC. (In communities where these tests are unavailable, the record shall reflect that the patient was informed of the role these tests play in evaluation of pregnancy, the options for obtaining such testing, and the risks of not obtaining such testing, including fetal demise or damage. In the event the patient refuses such tests, the record will reflect the facts of informed patient refusal.)

2. Documentation of consideration of induction by 42 weeks gestation and the rationale for proceeding with or delaying induction.

4. Evaluation of Fetal Size

a. Anticipate shoulder dystocia by:

1. Estimating fetal weight in prenatal visits and in early labor when fundal height is equal to or greater than 40 cm;

2. Document in the last weeks of pregnancy that a problem with disproportion is or is not anticipated;

3. For anticipated problems, if physician is not experienced in management of shoulder dystocia, the record shall reflect appropriate consultation with an obstetrician or a physician experienced in the management of shoulder dystocia. Unavailability of such expertise shall prompt discussion of transfer as discussed in paragraph 6.

b. Because of the high risk of vaginal breech deliveries, the decision as to method of delivery should be well documented, and all breech presentation pregnancies should be considered potential candidates for Caesarean Section. The record shall reflect the evaluation by the attending physician and the full informed consent or refusal of the patient regarding referral, Caesarean Section vs. vaginal delivery and/or transfer. OB consult shall be obtained for proposed vaginal delivery of breech.

5. Fetal Monitoring.

   Continuous electronic fetal monitoring is indicated with labor of all high risk pregnancies (see #1). Documentation of prompt response by the attending physician to an indication of abnormal fetal heart tracings is imperative. Use of fetal monitoring requires expertise in the interpretation by the physician and nursing staff in attendance. If the patient refuses electronic fetal monitoring at any time, that circumstance should be well documented, including the discussion of risk and alternatives with the patient.

6. Transfer Issues.

   When ultrasound is indicated but not available, practitioners in rural areas will inform patient of the role ultrasound could play in evaluating the pregnancy, the options available for obtaining such tests and the risk of refusing such testing, including fetal death or damage. If the patient refuses such tests, the record shall reflect informed patient refusal.

   Transfer to a level 2 or a level 3 perinatal unit should be accomplished on a timely basis with complication or high risk pregnancy. The record shall clearly indicate that the attending physician has fully informed the patient of her potential need for a level of care exceeding that available in the community; the options for obtaining such care; and the risks of refusing transfer including fetal death or damage. In the event the patient refuses transfer, her informed refusal should be well documented.

STATE OF ALASKA

LYMAN F. HOFFMAN
REPRESENTATIVE

P.O. BOX V
JUNEAU, ALASKA 99811
(907) 465-4530, 465-4453

HOUSE OF REPRESENTATIVES

DISTRICT 25
AKIACHAK
AKIAK
ATMAUTLUAK
BETHEL
CHEFORNAK
EEK
GOODNEWS BAY
KASIGLUK
KIPNUK
KONGIGANAK
KWETHLUK
KWIGILLINGOK
MEKORYUK
NAPAKIAK
NAPASKIAK
NEWTOK
NIGHTMUTE
NUNAPITCHUK
OSCARVILLE
PLATINUM
QUINHAGAK
TOKSOOK BAY
TUNTUTLIAK
TUNUNAK

April 7, 1989

M E M O R A N D U M

TO: All Representatives

FROM: Representative Lyman F. Hoffman Lyman

RE: Summary of Oil Spill Statutes and Laws

Attached please find a summary of financial remedies possible under State and Federal laws.

Thank you.

Attachment

P.O. Box 763 Bethel, Alaska 99559 (907) 543-3543

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

STATE OF ALASKA

LYMAN F. HOFFMAN
REPRESENTATIVE

P.O. BOX V
JUNEAU, ALASKA 99811
(907) 465-4530, 465-4453

HOUSE OF REPRESENTATIVES

DISTRICT 25
AKIACHAK
AKIAK
ATMAUTLUAK
BETHEL
CHEFORNAK
EEK
GOODNEWS BAY
KASIGLUK
KIPNUK
KONGIGANAK
KWETHLUK
KWIGILLINGOK
MEKORYUK
NAPAKIAK
NAPASKIAK
NEWTOK
NIGHTMUTE
NUNAPITCHUK
OSCARVILLE
PLATINUM
QUINHAGAK
TOKSOOK BAY
TUNTUTLIAK
TUNUNAK

April 7, 1989

M E M O R A N D U M

TO: All Representatives

FROM: Representative Lyman F. Hoffman

RE: Summary of Oil Spill Statutes and Laws

Attached please find a summary of financial remedies possible under State and Federal laws.

Thank you.

Attachment

P.O. Box 763 BETHEL, ALASKA 99559 (907) 543-3543

STATE OF ALASKA
THE LEGISLATURE

LEGISLATIVE AFFAIRS AGENCY

POUCH Y STATE CAPITOL
JUNEAU, ALASKA 99811
907 465 3800

MEMORANDUM April 6, 1989

SUBJECT: Overview of Oil Pollution Statutes
(Work Order No. 6-1171)

TO: Representative Lyman Hoffman

FROM: Terri Lauterbach
Legislative Counsel

You have asked for a general summary of state and federal statutes that are relevant to the Prince William Sound oil disaster, including statutes under which the state has financial remedies for damages and costs of cleanup.

As I'm sure you realize, many lawyers will be litigating many questions about the liability of Exxon and Alyeska for this disaster. Some will be litigating questions about state liability as well. Not all the facts are even available yet about some matters, such as who actually owned the Exxon Valdez, who owned the oil that was discharged, and who is responsible for the apparent lack of containment action in the critical first three days after the discharge.

Therefore, the following summary of statutes is intended as a general guide only. It is impossible at this point in time to express a well-founded opinion about the outcome of potential litigation on some of the issues that will be noted. If you desire a more full explanation on any point or in-depth legal research about any issue raised, feel free to ask for further assistance. In the meantime, I hope this general summary answers some of the basic questions about the statutes that will be at issue in future litigation or settlements concerning the Prince William Sound disaster.

BASIC LIABILITY STATUTES

The basic statutes that have apparently been violated are AS 46.03.740 and AS 46.03.822. They read, in pertinent part, as follows: