ALASKA LEGISLATURE COMMITTEE FILES, 1989-1990 8672
5916 HOUSE LABOR & COMMERCE

320

Representative Dave Donley, Chair
House Labor & Commerce Committee

DATE: November 30, 1989

PLACE: Fifth Floor Conf. Rm. Anchorage LIO

SUBJECT OF MEETING:
Continuation of Medical Liability Insurance Legislation and Issues
Proposed Legislation - Medical Malpractice Liability Insurance
HB 286 - Workplace Safety Violations
Proposed Wage and Hour Legislation

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?	
Debra C Grauc	AATL and AAT	PO Box 102323 Anchorage AK	99515		258-4040	Y	(N)		
Rick Union	ASMA	Box 020868 Juneau ~~99~~	99802			Y	(N)		
Mary Pierce	MICA	4000 Old Seward Hwy Suite 303	99503			Y	(N)		
Pam Ventgen	State Medical Board	3601 C St #722 Anch	99503		561-2878	Y	(N)		
Kristin Knudsen	Atty Gen's & GO Office	1031 W. 4th Ave #200	99501			Y	(N)		9:45
Shari Kochman	Governor	P.O. Box A Juneau 99811	99811	586-8031	465-3500	(Y)	N	HB 345	10:15
Nancy Horn	Lyn Latham	602 N Pine	9958	274-130	274-1301	Y	(N)		
Erika Mahaney	Ind. Wks. Assn.	608 No. Pine	9950	3749	2	Y	(N)		10:45
						Y	N		
						Y	N		
						Y	N		

HB

349

HOUSE COMMITTEE REPORT

(7)
Date Referred: May 6, 1989 FURTHER REFERRALS: JUDICIARY
FINANCE

Date of Committee Action: 3/7/90

The [redacted] Committee considered: [redacted]

HOUSE BILL NO. [redacted] [APPROPRIATED MALPRACTICE INS. MATCHING FUND]
"An Act making a special appropriation to the Alaska medical malpractice matching fund for medical malpractice insurance premiums; and providing for an effective date."

RECOMMENDATIONS:
[X] be replaced with CS HB 349 [✓] the same title
[ ] a new title
[ ] have attached amendment(s)
[✓] do pass
[ ] do not pass
[ ] no recommendation
[ ] individual recommendations
[ ] additional referral to the Judiciary Committee

ADOPTS: _____ letter of intent

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

APPROVES PREVIOUS: (Date/Dept)
[ ] fiscal note(s) _____
[ ] zero fiscal note(s) _____
[ ] zero fn/analysis _____

SIGNING DO PASS:

SIGNING: (Check approp. column)

	Do Not Pass	No Rec	Amend
[redacted]		X	
[redacted]		X	
[redacted]	X		
[redacted]		X	
[redacted]			

Dave Donley
Chairman's Signature

6-1381E✓
Ford
2/27/90

Funding Information: General Fund $500,000
Other Funds -0-
$500,000

Original sponsor(s): REP. DONLEY, Gruenberg, Boyer

IN THE HOUSE BY THE LABOR & COMMERCE COMMITTEE

CS FOR HOUSE BILL NO. 349 (L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act making a special appropriation to the Alaska medical malpractice matching fund for medical malpractice insurance premiums; and providing for an effective date."

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

* Section 1. The sum of $500,000 is appropriated to the Alaska medical malpractice matching fund (AS 21.88.310), from unexpended and unobligated funds repaid to the medical malpractice liability revolving loan fund (AS 21.88.210), for the purpose of paying medical malpractice insurance premiums.

* Sec. 2. The unexpended and unobligated balance of the appropriation made by this Act lapses into the general fund July 1, 1993.

* Sec. 3. This Act takes effect on the effective date of the section of an act enacted by the Sixteenth Alaska State Legislature that establishes the Alaska medical malpractice matching fund (AS 21.88.310).

HOUSE LABOR AND COMMERCE COMMITTEE
ALASKA STATE LEGISLATURE
P.O. BOX Y, JUNEAU 99811
(907) 465-3892

November 23, 1989

M E M O R A N D U M

To: Members, House Labor and Commerce Committee

From: Representative Dave Donley, Chair
House Labor and Commerce Committee

Re: HB 349 - Appropriation for the Alaska Medical Malpractice Matching Fund

HB 349 appropriates $500,000 from the medical malpractice liability revolving loan fund (AS 21.88.210) to the Alaska Medical Malpractice Matching Fund established in HB 350. The matching fund consists of appropriations by the legislature and is administred by the Medical Indemnity Corporation of Alaska (MICA).

The initial $500,000 appropriation will fund the first few years of the program although subsequent legislative appropriations may be necessary. Section 2 of the bill is a five year "sunset" clause providing that the unexpended and unobligated balance of the appropriation lapses into the general fund on July 1, 1995.

MICA representatives will testify on HB 349 and 350 during our November 29 and 30 public hearings. A Legislative Budget and Audit report on the medical malpractice revolving loan fund is included in your committee file.

dd/gbi89
b/hb349

STATE OF ALASKA

THE LEGISLATURE

BUDGET AND AUDIT COMMITTEE

AUDIT DIVISION
P.O. BOX W
JUNEAU, ALASKA 99811-3300

M E M O R A N D U M

DATE: June 13, 1989

TO: Chairmen of the Standing Committees

FROM: Randy S. Welker
Legislative Auditor
Division of Legislative Audit

SUBJECT: Release of Audits

On June 9, 1989, the Legislative Budget and Audit Committee approved for release to the public the enclosed audit report(s) which may be of interest to your Committee.

If you have any questions on the report(s), please contact our office (465-3830).

Enclosure(s)

Introduced: 5/6/89
Referred: Labor & Commerce
Judiciary and Finance

6-1381A

Funding Information
General Fund $500,000
Other Funds -0-
$500,000

IN THE HOUSE BY DONLEY AND GRUENBERG

HOUSE BILL NO. 349

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - FIRST SESSION

A BILL

For an Act entitled: "An Act making a special appropriation to the Alaska medical malpractice matching fund for medical malpractice insurance premiums; and providing for an effective date."

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

* Section 1. The sum of $500,000 is appropriated to the Alaska medical malpractice matching fund (AS 21.88.310), from unexpended and unobligated funds repaid to the medical malpractice liability revolving loan fund (AS 21.88.210), for the purpose of paying medical malpractice insurance premiums.

* Sec. 2. The unexpended and unobligated balance of the appropriation made by this Act lapses into the general fund July 1, 1995.

* Sec. 3. This Act takes effect on the effective date of the section of an act enacted by the Sixteenth Alaska State Legislature that establishes the Alaska medical malpractice matching fund (AS 21.88.310).

A REPORT ON THE
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
DIVISION OF INSURANCE
MEDICAL MALPRACTICE REVOLVING LOAN FUND

For the Fiscal Years Ended June 30, 1988 and 1987

Audit Control Number

08-1361-89-R

Commissioner, Department of Commerce and Economic Development	Larry Merculieff
Deputy Commissioner, Department of Commerce and Economic Development	Jeffrey W. Bush

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PURPOSE OF THE REPORT

In accordance with the provisions of Title 24 of the Alaska Statutes, we conducted an audit of the Department of Commerce and Economic Development, Division of Insurance, Medical Malpractice Revolving Loan Fund, to determine:

1. If the financial statements present fairly the financial position, results of operation, and changes in financial position for the fiscal years ended June 30, 1988 and 1987.

2. The division's compliance with applicable state statutes and regulations governing the fund's fiscal activities.

ORGANIZATION AND FUNCTION

The Medical Malpractice Revolving Loan Fund (MMRLF), operating under the authority of AS 21.88.210-.900 since 1978, provides capital surplus for the Medical Indemnity Corporation of Alaska (MICA) to ensure the availability of a medical malpractice insurance program to health providers in Alaska. MMRLF has been capitalized since inception by direct appropriations from the General Fund currently totalling $3,000,000.

MMRLF is administered by the Department of Commerce and Economic Development. Loans to provide surplus in respect to policyholders may not exceed a total of $3,000,000 oustanding at any time, and interest shall be paid on the outstanding balance at a rate equal to 7% a year. These loans shall be repaid in annual installments of at least 25% of the excess of premiums earned over the total of claims, reserves, expenses, and assessments made by the association, if any. If MICA is unable to procure reinsurance from a private casualty insurer, additional loans of up to $3,000,000 may be obtained. These additional loans must be repaid within five years at an annual interest rate of 6%.

MMRLF has made one loan to MICA for $3,000,000 which has been sold to the Department of Revenue. As of June 30, 1988, principal repayments of $597,714 have been made by the corporation reducing the principal outstanding on the first loan to $2,402,286.

In addition, MICA was unable to procure reinsurance during FY 87. Therefore MMRLF made an additional loan of $2,000,000. As of June 30, 1988, principal repayments of $400,000 have been made by the corporation reducing the principal outstanding on the second loan to $1,600,000.

FINDING AND RECOMMENDATION

Recommendation No. 1

The Department of Commerce and Economic Development should account for all related Medical Malpractice Revolving Loan Fund activity.

The Department of Commerce and Economic Development is accounting for interest revenue received on MMRLF's Division of Insurance-owned loan in one of the division's general fund collocation codes.

Although the interest should be credited to the General Fund as stated in the Notes to the Financial Statements, proper accounting and disclosure of the fund's activity requires that interest revenue initially be recorded in the fund. In a subsequent transaction or transactions, the revenue should then be transferred to the General Fund. Unless this entry or entries are done, revenues and expenses of the fund will be materially understated, and the financial statements will not reflect the true activity of the fund.

We recommend the department change their current procedures and coordinate with the Department of Administration, Division of Finance to ensure full disclosure is made of the fund's activity in its financial statements.

STATE OF ALASKA

THE LEGISLATURE

BUDGET AND AUDIT COMMITTEE

AUDIT DIVISION
P.O. BOX W
JUNEAU, ALASKA 99811-3300

February 15, 198.

Members of the Legislative Budget
and Audit Committee:

Independent Auditor's Report

We have audited the comparative balance sheet of the Medical Malpractice Revolving Loan Fund as of June 30, 1988 and 1987, and the related comparative statements of revenues, expenses, and changes in fund equity, and changes in financial position (cash basis) for the years then ended. These financial statements are the responsibility of the agency's management. Our responsibility is to express an opinion on these financial statements based on our audit.

We conducted our audit in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audit provides a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the Medical Malpractice Revolving Loan Fund as of June 30, 1988 and 1987, and the results of its operations and its changes in financial position (cash basis) for the years then ended in conformity with generally accepted accounting principles.

Randy S. Welker, CPA
Legislative Auditor
Division of Legislative Audit

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
DIVISION OF INSURANCE
MEDICAL MALPRACTICE REVOLVING LOAN FUND
COMPARATIVE BALANCE SHEET
June 30, 1988 and 1987

	1988	1987
Assets		
Cash	$1,400,000	$1,000,000
Loans Receivable	1,600,000	2,000,000
Total Assets	$3,000,000	$3,000,000
Fund Equity		
Contributions From General Fund	$3,000,000	$3,000,000

The Notes to the Financial Statements are an integral part of this Statement.

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
DIVISION OF INSURANCE
MEDICAL MALPRACTICE REVOLVING LOAN FUND
COMPARATIVE STATEMENT OF CHANGES IN FINANCIAL POSITION
(CASH BASIS)
For the Fiscal Years Ended June 30, 1988 and 1987

	1988	1987
Resources Provided		
Net Income	$ 107,574	$ 60,164
Decrease in Due From Other Funds	-0-	3,000,000
Decrease in Loans Receivable	400,000	-0-
Total Resources Provided	507,574	3,060,164
Resources Used		
Transfers To Other Funds	107,574	60,164
Increase in Loans Receivable	-0-	2,000,000
Total Resources Used	107,574	2,060,164
Increase in Cash	400,000	1,000,000
Cash at July 1	1,000,000	-0-
Cash at June 30	$1.400.000	$1.000.000

The Notes to the Financial Statements are an integral part of this Statement.

STATE OF ALASKA

STEVE COWPER, GOVERNOR

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

OFFICE OF THE COMMISSIONER

P.O. BOX D
JUNEAU, ALASKA 99811-0800
PHONE: (907) 465-2500

April 25, 1989

Mr. Randy S. Welker
Legislative Auditor
Division of Legislative Audit
P.O. Box W
Juneau, AK 99811-3300

Dear Mr. Welker:

I have received a copy of your "Confidential" preliminary audit report on:

> "A Report on the Department of Commerce and Economic Development, Division of Insurance, Medical Malpractice Revolving Loan Fund, for the Fiscal Years Ended June 30, 1988 and 1987."

I concur with the recommendation made regarding the accounting of interest received on the division's loan. Procedures will be changed to reflect the receipt of interest into the loan fund and a subsequent transaction will transfer the interest to the General Fund. The department's Division of Administrative Services, which processes these interest payments, will coordinate the procedural change with the Division of Finance.

I would like to take this opportunity to compliment your staff on their efforts and for the smoothness with which the audit was conducted.

Sincerely,

Larry Merculieff
Commissioner

LM/wfs0315q
42589a

CORRECTION

THIS DOCUMENT
HAS BEEN REPHOTOGRAPHED
TO ASSURE LEGIBILITY

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
DIVISION OF INSURANCE
MEDICAL MALPRACTICE REVOLVING LOAN FUND
COMPARATIVE BALANCE SHEET
June 30, 1988 and 1987

	1988	1987
Assets		
Cash	$1,400,000	$1,000,000
Loans Receivable	1,600,000	2,000,000
Total Assets	$3.000.000	$3.000.000
Fund Equity		
Contributions From General Fund	$3.000.000	$3.000.000

The Notes to the Financial Statements are an integral part of this Statement.

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
DIVISION OF INSURANCE
MEDICAL MALPRACTICE REVOLVING LOAN FUND
COMPARATIVE STATEMENT OF REVENUES, EXPENSES, AND CHANGES IN FUND EQUITY
For the Fiscal Years Ended June 30, 1988 and 1987

	1988	1987
Revenues		
Interest on Loans (Note 3)	$ 107,574	$ 60,164
Expenses	-0-	-0-
Net Income	107,574	60,164
Transfers To Other Funds	(107,574)	(60,164)
Fund Equity at Beginning of Year	3,000,000	3,000,000
Fund Equity at End of Year	$3.000.000	$3.000.000

The Notes to the Financial Statements are an integral part of this Statement.

STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
DIVISION OF INSURANCE
MEDICAL MALPRACTICE REVOLVING LOAN FUND
COMPARATIVE STATEMENT OF CHANGES IN FINANCIAL POSITION
(CASH BASIS)
For the Fiscal Years Ended June 30, 1988 and 1987

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STATE OF ALASKA
DEPARTMENT OF COMMERCE AND ECONOMIC DEVELOPMENT
DIVISION OF INSURANCE
MEDICAL MALPRACTICE REVOLVING LOAN FUND
NOTES TO THE FINANCIAL STATEMENTS
For the Fiscal Years Ended June 30, 1988 and 1987

Note 1 - Summary of Significant Accounting Policies

The financial statements are prepared on the accrual basis of accounting. Revenues are recognized at the time they are earned. Expenses are recognized when incurred.

Note 2 - Loan Information

There is currently one loan of $3,000,000 outstanding which has been purchased by the Department of Revenue. The loan has an indefinite repayment period at an interest rate of 7%. The Medical Indemnity Corporation of Alaska (MICA) must pay a late charge of 4% on any installment not received within 15 days of its due date. As of June 30, 1988, principal repayments of $597,714 have been made by the corporation reducing the principal outstanding to $2,402,286.

There is an additional loan of $2,000,000 outstanding. This loan is to be repaid within five years at an annual interest rate of 6%. MICA must pay a late charge of 4% on any installment not received within 15 days of its due date. As of June 30, 1988, principal repayments of $400,000 have been made by the corporation reducing the principal outstanding on the second loan to $1,600,000.

Hence, loans to MICA total less than the aggregate $6,000,000 allowable by AS 21.88.210(b)(2).

Note 3 - Interest Receipts

The Medical Malpractice Revolving Loan Fund (MMRLF) does not retain any of the interest receipts as revenue to the fund. Alaska Statute 21.88.210-.900 which established the fund, requires that repayments of principal be credited to the fund but is silent as to the treatment of interest. It is the Division of Insurance's position that the original intent of MMRLF was not to retain interest receipts, but rather that they be forwarded to the General Fund for reappropriation by the Legislature.

STATE OF ALASKA

DEPARTMENT OF COMMERCE & ECONOMIC DEVELOPMENT

OFFICE OF THE COMMISSIONER

STEVE COWPER, GOVERNOR

P. O. BOX D
JUNEAU, ALASKA 99811-0800
PHONE: (907) 465-2500

April 25, 1989

Mr. Randy S. Welker
Legislative Auditor
Division of Legislative Audit
P.O. Box W
Juneau, AK 99811-3300

Dear Mr. Welker:

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I would like to take this opportunity to compliment your staff on their efforts and for the smoothness with which the audit was conducted.

Sincerely,

Larry Merculieff
Commissioner

LM/wfs0315q
42589a

Alaska State Legislature

Legislative Research Agency

P.O. Box Y
Juneau, AK 99811-3100
Phone: (907) 465-3991
Fax: (907) 465-3551

HB 349

November 15, 1989

MEMORANDUM

TO: Representative Dave Donley

ATTN: Ginger Baim

FROM: Patricia Young PY
Legislative Analyst

RE: Medical Malpractice Insurance Premiums
Research Request 90.124

You asked this agency to ascertain whether any states have passed or are considering legislation which would prohibit insurers from classifying physicians into more than four groups for the purposes of determining medical malpractice liability premiums. You also wished to know the number of classifications used by insurers for Alaska physicians; the average cost of liability insurance for each class of physicians; and the estimated average cost if classifications were limited to four.

In addition, you asked if any states besides Arizona have adopted or are considering legislation which would create a matching fund to pay a portion of the cost of medical malpractice liability insurance premiums for physicians. You also wished to know how such laws are structured, i.e., whether assistance is limited to certain physician specialties, and whether assistance is based on a "sliding scale" of need or on a flat amount.

Limiting Classifications of Physicians

The limiting of classifications of physicians has been suggested by the National Insurance Consumer Organization (NICO) as a way of spreading the cost of malpractice insurance across a broader base of payees. This is one of several changes suggested by Robert Hunter, NICO president. (See Attachment A, "How to Solve the Medical Malpractice Crisis.") Neither Bob Boerner, of the National Council of State Legislatures (NCSL), nor Carol Brierly Golin, editor of the *Medical Liability Monitor*, which tracks state legislation in this area, are aware of any states which have enacted or are considering such legislation.

qualification, and no financial need must be demonstrated on the part of the physicians. The major criteria for qualification is that a physician practice in a rural area. The fund is used to subsidize the difference between premiums which include obstetrical care coverage and premiums without such coverage, for gynecologists and general practitioners. The maximum subsidy per physician is $30,000. Despite the informal nature of the requirements, only seven physicians are currently receiving this assistance.

Arizona has recently passed legislation to appropriate $195,000 from the state general fund to be used for financial assistance to physicians who provide obstetrical services in rural areas identified as obstetrically underserved. Family physicians who perform fewer than 50 deliveries per year are eligible to receive up to $5,000 per year; family physicians who perform more than 50 deliveries per year are eligible to receive up to $10,000 per year; obstetricians are also eligible to receive up to $10,000 per year.

North Carolina last year appropriated $240,000 to provide assistance to obstetricians and family practice physicians who provide prenatal and obstetrical services in areas of the state that are underserved in this regard. Regulations require that qualifying physicians may not refuse care to patients based on their ability to pay. According to Bob Burns, assistant director of government affairs, North Carolina State Medical Society, the fund subsidizes the difference between premiums with obstetrical care coverage and premiums without such coverage, with a maximum subsidy of $6,500 per physician. Funding has been continued at the same level for the current year. Mr. Burns noted that because the state has one of the highest infant mortality rates in the nation, proponents of this program are urging the legislature to increase the appropriation so that more physicians can participate.

In **Montgomery County, Maryland**, obstetricians are considered part-time county employees and are covered by the county's liability insurance when treating patients referred by the county. Physicians are covered by their own insurance when treating private patients. This program helps assure access to care for the medically indigent--patients who are frequently more high risk due to lack of prenatal care. According to Ken Heland, associate director of the American College of Obstetricians and Gynecologists and head of the Department of Professional Liability, in Maryland, insurance premiums are based partially on the number of deliveries physicians perform. Premiums for private practice have dropped because deliveries performed for county patients are not counted in liability calculations.

Copies of the Arizona and North Carolina bills are included in Attachment D. I hope you find this information useful.

Attachments

The Medical Indemnity Corporation of Alaska (MICA), which insures approximately 50 percent of Alaska's physicians, groups them into seven classes. As you will observe from MICA's current coverage and premium schedules (Attachment B), various factors determine cost. Averaging the cost of liability insurance per classification is possible; however, according to Art Stanford, MICA underwriting manager, such averaging will not reflect the actual experience of Alaska physicians. Mr. Stanford estimates that, by far, the greatest number of physicians are in the lower classifications, and he is unable to estimate the effect of limiting classifications.

The Medical Insurance Exchange of California (MIEC) insures the next greatest percentage of Alaska's physicians, with approximately 21 percent. This company groups physicians into ten classes. A copy of MIEC's current coverages and premiums schedules is Attachment C. According to Barbara Barnett, assistant underwriting manager, averaging actual premiums paid for each class would not be meaningful; averaging the cost per physician if classes were limited to four would likewise not produce meaningful information.

Such a change would result in less variation in premiums and would spread the cost of malpractice insurance across a broader base of payees; however, both Mr. Stanford and Ms. Barnett noted that a large number of physicians in low risk practice would be dissatisfied at subsidizing those in high risk practice, and they questioned the efficacy of the state's limiting classes with such a relatively small pool of physicians.[1] Ms. Barnett also commented that such legislation could adversely affect insurance availability because carriers might leave the state.

Obstetrical Care Incentive Programs

According to Ms. Golin, Hawaii, Arizona, and North Carolina have established funds to assist certain physicians with liability insurance premiums. Programs vary, but in each case the emphasis is on assistance for physicians who perform obstetrical services. A related program has also been initiated at the municipal level in Montgomery County, Maryland.

Hawaii was the first state to provide assistance of this kind. According to Becky Kendrall, assistant executive director of the Hawaii Medical Association, the state legislature in 1986 appropriated $125-$150,000 to subsidize those physicians in rural areas who perform obstetrical services. Applying physicians must submit copies of their insurance premiums, information on the number of Medicaid cases handled, and verification of the annual number of deliveries performed. Ms. Kendrall noted that the requirements are "quite informal." No specific percentage of indigent care is necessary for

---

[1]Although 905 physicians hold active licenses in the state, fewer may be practicing.

HB
350

6-1380E
Ford
2/27/90

Original sponsor(s): REP. DONLEY, Gruenberg, Boyer

IN THE HOUSE BY THE LABOR & COMMERCE COMMITTEE

CS FOR HOUSE BILL NO. 350 (L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to the medical malpractice revolving loan fund; creating the Alaska medical malpractice matching fund; and providing for an effective date."

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

* Section 1. SHORT TITLE. This Act may be known as the Alaska Childbirth Care Incentive Act.

* Sec. 2. FINDINGS AND PURPOSE. (a) The legislature finds that

(1) it is in the best interest of the state that physicians be insured in order to provide adequate compensation in cases of medical malpractice and to ensure that physicians providers are not required to bear unreasonable financial risks imposed by an uninsured claim;

(2) due to the cost of medical malpractice insurance some physicians have chosen to become uninsured, which exposes the physician and patients to unreasonable risk, forces some physicians to cease their medical practice, and also acts as a general disincentive to practicing medicine in the state;

(3) the number of physicians in the state on a per capita basis is among the lowest in the nation, particularly in the rural areas, and that the shortage of physicians is increasing; and

(4) in rural areas of the state the high cost of medical malpractice insurance poses a serious threat to public health and safety.

(b) It is the purpose of this Act to provide immediate and substantial relief to physicians by making adequate malpractice insurance available, while the legislature continues to develop legislation intended to

reduce the cost of medical malpractice insurance.

* Sec. 3. AS 21.88.210(b) is amended to read:

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

(1) to provide surplus in respect to policyholders that [WHICH] may not exceed a total of $3,000,000 outstanding at any time; these obligations shall be subordinated to all other obligations of the corporation; loans made under this paragraph shall be repaid to the fund in annual installments of at least 25 percent of the excess of premiums earned over the total of claims, reserves, expenses, and assessments made by the association, if any; interest may not be charged [SHALL BE PAID] on the outstanding balance [AT A RATE EQUAL TO SEVEN PER CENT A YEAR];

if the director determines that the corporation is unable to procure reinsurance from a private casualty insurer or reinsurer for any liability incurred by contracts issued by it, additional loans up to an aggregate of $6,000,000 when taken together with loans made under (1) of this subsection to compensate for fluctuations in loss experience; loans made under this paragraph shall be in parity with all other obligations of the corporation except that they shall be subordinated to obligations of policyholders and claimants for indemnity of loss; these loans shall be repaid within five years; interest may not be charged on the outstanding balance [AT AN ANNUAL INTEREST RATE OF SIX PER CENT].

* Sec. 4. AS 21.88 is amended by adding a new section to article 3 to read:

Sec. 21.88.310. MEDICAL MALPRACTICE MATCHING FUND. (a) The Alaska medical malpractice matching fund is established within the

Department of Commerce and Economic Development. The fund consists of legislative appropriations.

(b) The corporation shall administer the fund. Money in the fund may be expended to pay the cost of medical malpractice insurance incurred by physicians who are eligible under (c) of this section and to pay the cost of administering the fund.

(c) A physician who purchases at least the minimum malpractice insurance policy offered by the corporation is eligible to receive a payment from the fund. The amount a physician is eligible to receive is equal to a percentage of that portion of the physician's annual malpractice insurance premium that provides coverage for obstetrics and gynecology as follows:

(1) 10 percent, if the physician practices in an urban area;

(2) 50 percent, if the physician practices in a rural area and acts as the attending physician in 20 or more births a year;

(3) 100 percent, if the physician practices in a rural area and acts as the attending physician in at least one but fewer than 20 births a year, or provides prenatal care to at least one but fewer than 20 patients a year.

(d) If a physician eligible to receive a payment under (c) of this section practices in both a rural and an urban area, the amount the physician receives shall be prorated under guidelines established by the corporation. The corporation may not pay an insurance surcharge imposed on a physician's medical malpractice insurance.

(e) The corporation shall establish procedures for applying for matching funds provided under this section.

(f) The state shall indemnify the corporation for any legal costs, attorney fees, or judgments that result from the administration

or operation of the fund.

(g) In this section,

(1) "hospital" has the meaning given in AS 18.20.210;

(2) "physician" means a person licensed to practice medicine under AS 08.64;

(3) "rural area" means an area located 60 or more miles from a hospital;

(4) "urban area" means an area located less than 60 miles from a hospital.

* Sec. 5. AS 21.88.310 is repealed July 1, 1993.

* Sec. 6. This Act takes effect immediately under AS 01.10.070(c).

6-1380E
Ford
3/1/90

Original sponsor(s): REP. DONLEY, Gruenberg, Boyer

IN THE HOUSE BY THE LABOR & COMMERCE COMMITTEE

CS FOR HOUSE BILL NO. 350 (L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

SIXTEENTH LEGISLATURE - SECOND SESSION

A BILL

For an Act entitled: "An Act relating to the medical malpractice revolving loan fund; creating the Alaska medical malpractice matching fund; and providing for an effective date."

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

* Section 1. SHORT TITLE. This Act may be known as the Alaska Childbirth Care Incentive Act.

* Sec. 2. FINDINGS AND PURPOSE. (a) The legislature finds that

(1) it is in the best interest of the state that physicians be insured in order to provide adequate compensation in cases of medical malpractice and to ensure that physicians providers are not required to bear unreasonable financial risks imposed by an uninsured claim;

(2) due to the cost of medical malpractice insurance some physicians have chosen to become uninsured, which exposes the physician and patients to unreasonable risk, forces some physicians to cease their medical practice, and also acts as a general disincentive to practicing medicine in the state;

(3) the number of physicians in the state on a per capita basis is among the lowest in the nation, particularly in the rural communities, and that the shortage of physicians is increasing; and

(4) in rural communities of the state the high cost of medical malpractice insurance poses a serious threat to public health and safety.

(b) It is the purpose of this Act to provide immediate and substantial relief to physicians by making adequate malpractice insurance available, while the legislature continues to develop legislation intended to

reduce the cost of medical malpractice insurance.

* Sec. 3. AS 21.88.210(b) is amended to read:

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

(1) to provide surplus in respect to policyholders that [WHICH] may not exceed a total of $3,000,000 outstanding at any time; these obligations shall be subordinated to all other obligations of the corporation; loans made under this paragraph shall be repaid to the fund in annual installments of at least 25 percent of the excess of premiums earned over the total of claims, reserves, expenses, and assessments made by the association, if any; interest may not be charged [SHALL BE PAID] on the outstanding balance [AT A RATE EQUAL TO SEVEN PER CENT A YEAR];

(2) if the director determines that the corporation is unable to procure reinsurance from a private casualty insurer or reinsurer for any liability incurred by contracts issued by it, additional loans up to an aggregate of $6,000,000 when taken together with loans made under (1) of this subsection to compensate for fluctuations in loss experience; loans made under this paragraph shall be in parity with all other obligations of the corporation except that they shall be subordinated to obligations of policyholders and claimants for indemnity of loss; these loans shall be repaid within five years; interest may not be charged on the outstanding balance [AT AN ANNUAL INTEREST RATE OF SIX PER CENT].

* Sec. 4. AS 21.88 is amended by adding a new section to article 3 to read:

Sec. 21.88.310. MEDICAL MALPRACTICE MATCHING FUND. (a) The Alaska medical malpractice matching fund is established within the

Department of Commerce and Economic Development. The fund consists of legislative appropriations.

(b) The corporation shall administer the fund. Money in the fund may be expended to pay the cost of medical malpractice insurance incurred by physicians who are eligible under (c) of this section and to pay the cost of administering the fund.

(c) A physician who purchases at least the minimum malpractice insurance policy offered by the corporation is eligible to receive a payment from the fund. The amount a physician is eligible to receive is equal to a percentage of that portion of the physician's annual malpractice insurance premium that provides coverage for obstetrics and gynecology as follows:

(1) 25 percent, if the physician practices in an urban community;

(2) 50 percent, if the physician practices in a rural community and acts as the attending physician in 20 or more births a year;

(3) 100 percent, if the physician practices in a rural community and acts as the attending physician in at least one but fewer than 20 births a year, or provides prenatal care to at least one but fewer than 20 patients a year.

(d) If a physician eligible to receive a payment under (c) of this section practices in both a rural and an urban community, the amount the physician receives shall be prorated under guidelines established by the corporation. The corporation may not pay an insurance surcharge imposed on a physician's medical malpractice insurance.

(e) The corporation shall establish procedures for applying for matching funds provided under this section.

(f) The state shall indemnify the corporation for any legal

costs, attorney fees, or judgments that result from the administration or operation of the fund.

(g) In this section,

(1) "physician" means a person licensed to practice medicine under AS 08.64;

(2) "rural community" means a community with less than 5,000 permanent residents and less than 10,000 permanent residents within a radius of 20 miles from the U.S. Post Office nearest to the center of the community;

(3) "urban community" means a community with 5,000 or more permanent residents or 10,000 or more permanent residents within a radius of 20 miles from the U.S. Post Office nearest to the center of the community.

* Sec. 5. AS 21.88.310 is repealed July 1, 1993.

* Sec. 6. This Act takes effect immediately under AS 01.10.070(c).

HOUSE LABOR AND COMMERCE COMMITTEE

ALASKA STATE LEGISLATURE P.O. BOX Y, JUNEAU 99811

(907) 465-3892

November 23, 1989

M E M O R A N D U M

To: Members, House Labor and Commerce Committee

From: Representative Dave Donley, Chair
House Labor and Commerce Committee

Re: HB 350 - Alaska Medical Malpractice Matching Fund

HB 350 establishes the Alaska medical malpractice matching fund under the Department of Commerce and Economic Development, to be administered by the Medical Indemnity Corporation of Alaska (MICA). The fund may be used to pay part of the cost of medical malpractice insurance for eligible physicians.

The purpose of HB 350 is outlined in Section 1 of the bill. The sliding scale established under the Act to determine eligibility for reimbursement from the matching fund is geared toward physicians who provide "high risk" care to local communities, such as OB-GYN and emergency room services and are therefore the ones who usually pay the highest premiums.

An initial appropriation of $500,000 is made to the matching fund through HB 349, the companion funding bill. The funding source is the medical malpractice liability revolving loan fund under AS 21.88.210. Only physicians insured by MICA are eligible for the matching fund.

A copy of a recently enacted Arizona law establishing a similar program is included in your committee file along with related information from the Legislative Research Agency. Representatives from MICA and other interested providers will testify on HB 349 and HB 350 during our November public hearings.

dd/gbi89
b/hb350

Alaska State Legislature

Legislative Research Agency

P.O. Box Y
Juneau, AK 99811-3100
Phone: (907) 465-3991
Fax: (907) 463-3351

November 15, 1989

MEMORANDUM

TO: Representative Dave Donley

ATTN: Ginger Baim

FROM: Patricia Young PY
Legislative Analyst

RE: Medical Malpractice Insurance Premiums
Research Request 90.124

You asked this agency to ascertain whether any states have passed or are considering legislation which would prohibit insurers from classifying physicians into more than four groups for the purposes of determining medical malpractice liability premiums. You also wished to know the number of classifications used by insurers for Alaska physicians; the average cost of liability insurance for each class of physicians; and the estimated average cost if classifications were limited to four.

In addition, you asked if any states besides Arizona have adopted or are considering legislation which would create a matching fund to pay a portion of the cost of medical malpractice liability insurance premiums for physicians. You also wished to know how such laws are structured, i.e., whether assistance is limited to certain physician specialties, and whether assistance is based on a "sliding scale" of need or on a flat amount.

Limiting Classifications of Physicians

The limiting of classifications of physicians has been suggested by the National Insurance Consumer Organization (NICO) as a way of spreading the cost of malpractice insurance across a broader base of payees. This is one of several changes suggested by Robert Hunter, NICO president. (See Attachment A, "How to Solve the Medical Malpractice Crisis.") Neither Bob Boerner, of the National Council of State Legislatures (NCSL), nor Carol Brierly Golin, editor of the *Medical Liability Monitor*, which tracks state legislation in this area, are aware of any states which have enacted or are considering such legislation.

The Medical Indemnity Corporation of Alaska (MICA), which insures approximately 50 percent of Alaska's physicians, groups them into seven classes. As you will observe from MICA's current coverage and premium schedules (Attachment B), various factors determine cost. Averaging the cost of liability insurance per classification is possible; however, according to Art Stanford, MICA underwriting manager, such averaging will not reflect the actual experience of Alaska physicians. Mr. Stanford estimates that, by far, the greatest number of physicians are in the lower classifications, and he is unable to estimate the effect of limiting classifications.

The Medical Insurance Exchange of California (MIEC) insures the next greatest percentage of Alaska's physicians, with approximately 21 percent. This company groups physicians into ten classes. A copy of MIEC's current coverages and premiums schedules is Attachment C. According to Barbara Barnett, assistant underwriting manager, averaging actual premiums paid for each class would not be meaningful; averaging the cost per physician if classes were limited to four would likewise not produce meaningful information.

Such a change would result in less variation in premiums and would spread the cost of malpractice insurance across a broader base of payees; however, both Mr. Stanford and Ms. Barnett noted that a large number of physicians in low risk practice would be dissatisfied at subsidizing those in high risk practice, and they questioned the efficacy of the state's limiting classes with such a relatively small pool of physicians.[1] Ms. Barnett also commented that such legislation could adversely affect insurance availability because carriers might leave the state.

Obstetrical Care Incentive Programs

According to Ms. Golin, Hawaii, Arizona, and North Carolina have established funds to assist certain physicians with liability insurance premiums. Programs vary, but in each case the emphasis is on assistance for physicians who perform obstetrical services. A related program has also been initiated at the municipal level in Montgomery County, Maryland.

Hawaii was the first state to provide assistance of this kind. According to Becky Kendrall, assistant executive director of the Hawaii Medical Association, the state legislature in 1986 appropriated $125-$150,000 to subsidize those physicians in rural areas who perform obstetrical services. Applying physicians must submit copies of their insurance premiums, information on the number of Medicaid cases handled, and verification of the annual number of deliveries performed. Ms. Kendrall noted that the requirements are "quite informal." No specific percentage of indigent care is necessary for

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[1]Although 905 physicians hold active licenses in the state, fewer may be practicing.

qualification, and no financial need must be demonstrated on the part of the physicians. The major criteria for qualification is that a physician practice in a rural area. The fund is used to subsidize the difference between premiums which include obstetrical care coverage and premiums without such coverage, for gynecologists and general practitioners. The maximum subsidy per physician is $30,000. Despite the informal nature of the requirements, only seven physicians are currently receiving this assistance.

Arizona has recently passed legislation to appropriate $195,000 from the state general fund to be used for financial assistance to physicians who provide obstetrical services in rural areas identified as obstetrically underserved. Family physicians who perform fewer than 50 deliveries per year are eligible to receive up to $5,000 per year; family physicians who perform more than 50 deliveries per year are eligible to receive up to $10,000 per year; obstetricians are also eligible to receive up to $10,000 per year.

North Carolina last year appropriated $240,000 to provide assistance to obstetricians and family practice physicians who provide prenatal and obstetrical services in areas of the state that are underserved in this regard. Regulations require that qualifying physicians may not refuse care to patients based on their ability to pay. According to Bob Burns, assistant director of government affairs, North Carolina State Medical Society, the fund subsidizes the difference between premiums with obstetrical care coverage and premiums without such coverage, with a maximum subsidy of $6,500 per physician. Funding has been continued at the same level for the current year. Mr. Burns noted that because the state has one of the highest infant mortality rates in the nation, proponents of this program are urging the legislature to increase the appropriation so that more physicians can participate.

In **Montgomery County, Maryland**, obstetricians are considered part-time county employees and are covered by the county's liability insurance when treating patients referred by the county. Physicians are covered by their own insurance when treating private patients. This program helps assure access to care for the medically indigent--patients who are frequently more high risk due to lack of prenatal care. According to Ken Heland, associate director of the American College of Obstetricians and Gynecologists and head of the Department of Professional Liability, in Maryland, insurance premiums are based partially on the number of deliveries physicians perform. Premiums for private practice have dropped because deliveries performed for county patients are not counted in liability calculations.

Copies of the Arizona and North Carolina bills are included in Attachment D. I hope you find this information useful.

Attachments

ATTACHMENT A
"How to Solve the Medical Malpractice Crisis"

HOW TO SOLVE THE MEDICAL MALPRACTICE "CRISIS"

Illustrations by Richard Thompson

By J. Robert Hunter

SURPRISE: IN POINT OF FACT, THE MEDICAL MALpractice system in the United States is actually something of a bargain. According to the latest data from the National Association of Insurance Commissioners, 1987 premiums for medical practice totaled $4.6 billion. This number may sound huge by itself, but remember that there were 240 million people living in the United States at that time. So for each of them, the total cost for the current malpractice system averaged $19—not a ruinously high figure, most would concede, and one that compares well with the $133 that the *average* American spends on tobacco products.

What has been dubbed as a medical malpractice "crisis" is *not* a consequence of out-of-control costs for the aggregate system, no matter how you look at it. Measured against the yardstick of total medical costs, the system still looks reasonable. Americans spent a whopping $404 billion on health care in 1988; even if medical malpractice costs were capped at zero, the bill for the nation's health care would only decline by 1.2%. I dare say that if you had no system to compensate victims of malpractice, and someone offered to do it for you for a percentage this small, you'd probably grab it.

There's no need to lose any sleep worrying about the financial fate of the medical malpractice insurers. According to the U.S. General Accounting Office, "the medical malpractice line yielded a profit of $2.2 billion over the eleven-year period 1975 through 1985. . . . As a percentage of premiums earned, the medical malpractice line's cumulative rate of return . . . was a positive 15.3 percent when the reserves were discounted" (U.S. Government Accounting Office report, "Insurance: Profitability of the Medical Malpractice and General Liability Lines," June 13, 1987).

Since medical malpractice insurers write about $2 of premium for each $1 of net worth, insurers made about 30% on equity during this eleven-year period—an impressively lofty rate of return.

Since 1985, rates of return for medical malpractice insurers have risen by 10% over the eleven-year average cited by GAO.

Here's another, rather telling, fact about the medical malpractice insurance business. Between 1977 and 1987, U.S. medical malpractice insurers took in more than five times as much in premiums as they paid out in claims, according to A.M. Best's. Then, too, when insurance companies say that they had an "underwriting loss," that does not mean that they actually paid out more than they took in. Rather, it means that they estimate that they will eventually pay out more than they took in. As a result, even when companies have an "underwriting loss," they almost always take in much more than they pay out.

Since 50% of malpractice claims are not paid until about eight years after the policy is written, the under-

J. Robert Hunter is president, National Insurance Consumer Organization, Alexandria, Virginia.

writing loss figure is particularly misleading for medical malpractice insurance. On the one hand, the insurance company invests and earns interest on the money it keeps, while on the other hand, it deducts the entire amount for accounting purposes in the first year. Comparing current-dollar income with future-dollar expenses is really quite misleading.

Costs Aren't Allocated Fairly

Although the total cost of medical malpractice insurance is relatively low—about 1% of total health care costs—that cost is poorly allocated. Doctors in high-risk specialties are the victims of this misallocation.

Further, it is the good doctors (the overwhelming majority) who subsidize the bad doctors. Although study after study has shown that only a small percentage of doctors are responsible for a sizable percentage of malpractice, doctors who have never been sued pay the same premium as a doctor who's been found liable for malpractice several times.

Here's a sample of these data. In the Michigan "Report on the Liability Crisis" (1985), 19.3% of doctors were found to have accounted for 72.2% of all claims, whereas 58.1% had had no claims. Similarly, in a somewhat earlier study, the Florida Insurance Commissioner's "Closed Claims Study of Medical Malpractice Insurance, 1975-82," 0.7% of the doctors accounted for 24% of the claims; one doctor was the subject of thirty-one claims. S. Ferber and B. Sheridan reported, in "Six Cherished Malpractice Myths Put to Rest" that, in Los Angeles, 0.6% of the doctors accounted for 30% of all payments (*Medical Economics*, vol. 52, 1975, p. 150).

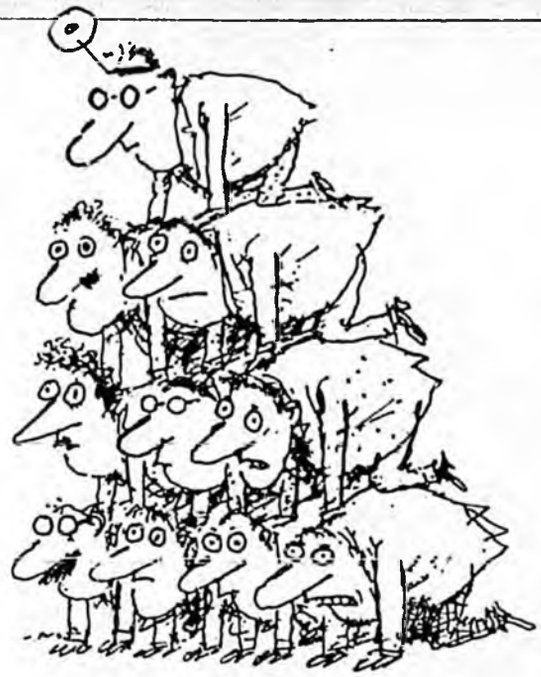
Unlike auto insurance, where accidents and tickets mean higher premiums, most medical malpractice insurance doesn't stipulate surcharges for physicians who have been successfully sued.

Finally, the doctors who perform few procedures subsidize those who do many procedures. Under the rating system now in use in most states, the rural general practitioner who delivers only a few babies every year can pay as much as an urban obstetrician/gynecologist who delivers hundreds of babies.

Insurance companies also tend to divide doctors into too many categories, with too few doctors in some. As a result, one big judgment against a doctor in a sparsely populated category can mean a huge increase in premiums for all of the doctors in that category. If the numbers of categories were reduced, and the numbers of doctors in each category increased, insurance premiums would decrease dramatically for the doctors in the high-risk specialties (at the same time, coverage costs for physicians in other categories would rise slightly).

If you can picture the various medical specialties arranged in a pyramid, with the relatively numerous general practitioners (GPs) at the bottom and the relatively few specialists at the top, the problem becomes easier to visualize.

When a person with a bad back goes to his or her GP,



the likelihood of a major malpractice suit arising from that visit is negligible. But if the back proves to be a serious medical problem, the patient will be referred up the specialty pyramid to the neurosurgeon. In Colorado, the leading insurer has only 233 of these among its 3,744 insureds.

It violates the insurance spread-of-risk principle to force so much through such a narrow base. (Even though neurosurgeons' net income, after medical malpractice premiums, is excellent—$200,000 a year—according to *Medical Economics*' gross and net income reports.)

Why must the defense costs for the convoluted suits that neurosurgeons *win* be spread among only the neurosurgeons? Why shouldn't the referring physician and the hospital granting privileges bear some of the cost of successful suits (as incentives for safer referrals/privilege granting)?

Which brings another point to mind: Doctors, in many instances, are forced to pay for damages, when in fact it is the hospital that should pay. Today, when negligence occurs in a hospital (for instance, in connection with surgery or delivering babies), the insurer for the doctor doing the surgery or delivering the baby often must pay for the negligence. So the hospital, in many cases, lacks sufficient incentive to police the doctors who practice under its roof; the cost of high-risk care is therefore borne solely by a small group of doctors.

If procedures done in a doctor's office were charged to doctors, while procedures performed in hospitals were charged to hospitals, the cost of high-risk care would be spread over a large number of beds, hospitals would have more incentive to police doctors, and malpractice insurance premiums for most doctors would drop. Studies cited in a recent publication from Public Citizens Health Research Group ("Medical Malpractice: The Need for Disciplinary Reform, Not Tort Reform," August 1985) unanimously concluded that discipline for practicing physicians is woefully inadequate.

Excessive Rates?

Medical malpractice insurers—and particularly the doctor-owned insurers—have raised their rates, more than is actuarially justified, in response to "suggestions" from Lloyd's of London and other reinsurers.

According to John Spinella, president of the physician-owned malpractice insurance company in Maryland, "in order to keep [Lloyd's] participation on cover we had to agree to some strong suggestions from the reinsurer to beef up the rate charged to the OBs" (statement before the Governor's Task Force on Medical Malpractice, October 22, 1985).

COPIC Insurance Company in Colorado was required by its reinsurer, North American Reinsurance Company, not to discount reserves or otherwise reflect investment income in setting prices, thereby driving up the premium charged to doctors dramatically, even though that action was in violation of Colorado ratemaking requirements.

In addition, requests for rate increases are often based on false assumptions. For example, the Maryland Mutual sought a 29% increase in 1985 based on the assumption that it would earn a 5% annual return on its investments (although it had traditionally earned, and was currently earning, more than 9%) and that inflation would be in excess of 10% (inflation at that time was well under 10%). If proper assumptions had been made, the insurance company would have needed a 10.5% *reduction* in its rates, rather than a 29% increase, to maintain its current rate of return.

Nor would tort reform, that ubiquitously mentioned *deus ex machina*, be of much help.

In testifying before the Maryland governor's task force, John Spinella admitted that "Even if every one of the Task Force's recommendations [on tort reform] were fully implemented, we doubt that there would be any discernible change and fear that problems would be exacerbated." And a 1985 study for the U.S. Health Care Financing Administration analyzed the effect of caps on awards and other limitations on malpractice suits enacted during the mid-1970s, and concluded that these "reforms" did not result in lower insurance premiums.

In Florida, St. Paul Fire and Marine Co. has undertaken closed-claim studies which, it says, show that the savings resulting from five major tort reforms proposed for that state (eliminating the collateral source rule, capping non-economic damages, restricting of joint and several liability, limiting punitive damages, and requiring periodic payment of future economic damages) would have "no effect."

How to Lower Insurance Rates

1. Require insurance companies to experience-rate doctors.

Drivers who have been in several serious auto accidents pay more, while drivers who have never had an accident pay less. Yet doctors found liable for malpractice several times pay the same as doctors who have never been sued. This doesn't make sense; good doctors, like good drivers, should pay less, and doctors involved in malpractice, like drivers involved in accidents, should pay more. Also, doctors who do fewer procedures ought to pay less than those who do many.

2. Reduce the number of categories of doctors and increase the number of doctors in each category.

In this way, risks will be spread as widely as possible.

3. Charge any malpractice that occurs in doctors' offices to doctors, and malpractice that happens in hospitals to hospitals.

This allocation will serve to maximize hospitals' incentive to police staff physicians and spread risks more widely.

4. Tighten state regulation of malpractice insurance.

Insurance companies are *exempt* from antitrust laws, so price fixing is legal. In one southern jurisdiction, all five insurers charge the same rate. Insurer inefficiency results. The average malpractice writer in the nation spends 43% of the premium dollar on expenses; there are also more efficient writers who spend only 12% to 15% for expenses.

5. Penalize frivolous suits and defenses.

Plaintiffs' attorneys should be penalized for bringing suits that are not solidly based on potential negligence. Defense attorneys (who get paid by the hour, win or lose) have little incentive to expedite proceedings.

6. Limit lawyer fees.

Limiting fees, however, has to be done in a balanced way, so that both plaintiff and defense attorneys' fees are controlled at the same time.

7. Focus on peer review.

The best way to bring down malpractice premiums is to reduce the incidence of malpractice. Peer review is very poorly done in most states, because of fear of lawsuits for antitrust or slander, camaraderie among doctors, lack of funding, poor information, and so on. So this constitutes another prime area for reform of the medical malpractice system. □

ATTACHMENT B
Medical Indemnity Corporation of Alaska (MICA) 1989
Professional Liability Coverages and Premium Schedules

MICA

Medical Indemnity
Corporation of Alaska

ALEUT PLAZA OFFICE BUILDING
4000 OLD SEWARD HIGHWAY, SUITE 203
ANCHORAGE, ALASKA 99503
TELEPHONE (907) 563-3414

1989

Physician's and Surgeon's
Professional Liability Coverages and Premium Schedules

Death or Total and Permanent Disability:

A Reporting Endorsement (tail coverage) will be issued at no extra cost because of death or permanent and total disability.

New Doctor Rule:

For physicians entering private practice for the first time following completion of medical school, residency training, military or public health service, premiums will be discounted 25 % for the first year of coverage.

Claims Free Premium Discount:

A 20 % premium discount will be provided to our insured physicians for a five year claims free history. This policyholder benefit will be provided upon renewal following the completion of the fifth year in which a claims free record has been demonstrated.

Claims Experience Premium Surcharges:

Claims experience premium surcharges may be imposed upon insureds with two or more claims in the last three years in which some elements of negligence or other contributing adverse factors are involved.

Employee Coverages:

Unlike many policies, most employees are provided coverage under the MICA policy.

Employee surcharges are limited to (1) Advanced Nurse Practitioners or Physician's Assistants added to a physician's or clinic's policy subject to 50 % of Class 1 premium (shares policy limits with employer, sponsor or supervising physician). (2) Physician's Assistants or Nurse Practitioners on policies providing separate limits of liability from sponsoring/supervising physician, subject to higher premium based upon specialty and practice situation; (3) employed Nurse Midwives or directly supervised Certified Registered Nurse Anesthetists (CRNAs) are subject to 100 % Class 3 annual premium; (4) unsupervised CRNAs or Nurse Midwives are subject to 100 % of Class 4 and Class 4A premium respectively.

No additional premium charges are incurred for other employees.

Locum Tenens:

MICA provides up to 60 days of coverage annually for a temporary substitute physician - locum tenens - for surgical and non-surgical specialties. Completion of application and *prior approval* of MICA is required.

This coverage is limited to 6 separate periods per year (except for illness or family emergencies of the insured physician) and any additional periods will involve customary premium charges.

Part Time Practitioners:

Class 1, 2, 2-A and 2-B: 35 % of the scheduled annual premiums for 10 hours or less per week practice; 65 % of the scheduled annual premium for 20 hours or less per week practice.

Short Term Practice Situations:

Pro-rated amount of annual premium computed on <u>short rate tables</u> subject to $250 minimum premium.

Comprehensive General Liability Coverages:

This optional coverage is available at $50 per physician covered, subject to the same limits of liability carried for professional liability. This coverage extends to bodily injury and property damage liability protection for those injuries accidentally sustained on the office premises by the general public.

This coverage is limited to only those premises actually occupied by our insured in rendering professional services. For example, if an insured occupied only one suite of a building, coverage would be limited to only that suite and not the entire building and parking lots. An entire building cannot be covered under the Comprehensive General Liability Endorsement unless the insured or the insured's employees occupy the entire building in the rendering of medical services.

Corporate/Partnership/Group Professional Liability:

This optional coverage is available at no additional charge to solo practitioners and group practices, providing each member or employed physician carries coverage through the Company. Limits of each physician's coverage must be equal to that carried by the group. The separate limits of liability for the corporation/partnership/group does not apply to policyholders who are solo practitioners nor does it apply concurrently or on an excess basis to the physician (s) scheduled on the policy or associated with the same medical organization who also allegedly provided negligent patient care for the same occurrence.

This form provides individual limits of liability to each physician named on the policy schedule in an amount equal to the limits of liability stated on the declarations page of the policy except these limits shall not be concurrent nor excess to the corporate limits of liability as stated in the previous paragraph.

Optional <u>Shared Limits</u> Professional Liability Group Coverage:

This optional coverage is available through the Company for your group at reduced premium levels. (See discount schedule that follows). One master policy is issued with each associated or employed physician covered by endorsement.

Coverages are limited to the course and scope of employment or association with your group. **The combined clinic/ group insureds are subject to the single limits of liability per occurrence and annual aggregate limits as procured.** Completion of the Physician's and Surgeon's Professional Liability Group Application is required, along with completion of individual application for each physician to be insured.

Discounts Per Limits of Liability

# Doctors on Policy	$500,000	$1,000,000
1	0	0
2	9%	7%
3	11%	9%
4	12%	10%
5	13%	11%
6	14%	12%
7	15%	13%
8	16%	14%
9+	17%	15%

Installments - Deferred Payments:

Initial policy issuance subject to deposit of $1,000 or two month's annual premium. Deferred payments are available in quarterly or semi-annual installments payable: 35%, 25 %, 25 % and 15 % quarterly or 60 % and 40 % semi-annually. Premium invoices should be paid upon receipt and the policy is subject to immediate cancellation if payment is not received by the first day of the quarter in which the premium is earned. Carrying charges are computed at 10 % annual simple interest on the unpaid balance.

PHYSICIAN'S RATE CLASSIFICATIONS

Class 1
Neurology
Psychiatry - excluding ECT;
Physicians - no surgery. Applies to general practitioners and physician specialists who do not perform obstetrical procedures or surgery (other than incision of boils and superficial abscesses or suturing of skin and superficial fascia) who do not ordinarily assist in surgical procedures.

Class 2
Neonatology
Opthalmology (Excluding Radial Keratotomy)
Physicians - minor surgery or assisting in major surgery. * Applies to general practitioners and physician specialists who perform minor surgery (including catheterization) or assist in major surgery.

Class 2-A
Emergency Medicine

Class 3
Physicians who include obstetrical procedures as any part of their practice. (May still be indicated as class 2-B on policy:)
Physicians - major surgery *
Proctology
Otorhinolaryngology
Abdominal Surgery
General Surgery
Pediatric Surgery
Thoracic Surgery
Traumatic Surgery
Plastic and Reconstructive Surgery, excluding cosmetic surgery
Urology
Gynecology (No Obstetrics)

Class 4
Anesthesiology

Class 4-A
Physicians - major surgery
Therapeutic Radiology
Obstetrics - Gynecology
Cardiovascular Surgery
Hand Surgery
Plastic and Reconstructive Surgery, including cosmetic surgery
Vascular Surgery
Orthopedic Surgery, excluding total joint procedures, spinal surgery and insertion of prosthetic devices.

Class 5
Physicians - major surgery
Neurosurgery
Orthopedic Surgery, including total joint procedures, spinal surgery and insertion of prosthetic devices.

* **Major Surgery** - involves operations in or upon any body cavity including but not limited to the cranium, thorax, abdomen or pelvis, or any other operation that presents a distinct hazard to life because of the condition of a patient or the lenghth or circumstances of an operation. It also includes removal of tumors (except skin tumors), open bone fractures, amputations, abortions, removal of any gland or organ, plastic surgery and any operations using general anesthesia.

NOTE: IF A PORTION OF THE PHYSICIAN'S PRACTICE IS IN A SPECIALTY WITH A HIGHER CLASS THAN HIS NORMAL SPECIALTY, HE OR SHE WILL BE PLACED IN THE HIGHER SPECIALTY FOR RATING PURPOSES.

PROFESSIONAL LIABILITY COVERAGES

Explanation of Policy:

The Claims-Made Policy extends professional liability protection to the physician, clinic or employee for claims reported in a single year, regardless of when service is rendered as long as the incident occurred while continuously insured under Claims-Made with MICA. Thus, claims reported this year are covered by this year's policy; claims reported next year by next year's policy and so on.

MICA's premium rates are derived from the historical pattern of reported claims resulting from the performance of professional services which form a "stair step" with an increasing number of claims being reported each year until the fifth year. In the first year, only about 19 % of the total claims resulting from professional services are reported; the second 39 %; the third 78 %; the fourth 93 %; the fifth and subsequent years, about 100 %.

Cost:

In keeping with the "stair step" development of claims, the rates charged for the Claims-Made policy mature at the fifth year. Subsequent renewal policies are charged at the mature rates. The specific cost of coverage is shown within our table entitiled CLAIMS-MADE PREMIUM SCHEDULE.

All policies issued by MICA are renewed on January 1 of each year. Your first years and renewal rates are pro-rated from the first date of coverage (inception date) of the original policy. For example, if your continuous coverage became effective on July 1, 1985, your annual renewal premium on January 1, 1989 would be pro-rated from January 1 through June 30 on the fourth year rates and from July 1 through December 31 on the fifth year rates.

Limits of Liability:

MICA's professional and optional comprehensive general liability coverages are available with policy limits of:

$200,000 per occurrence/$600,000 aggregate per calendar year.
$500,000 per occurrence/$1,000,000 aggregate per calendar year.
$1,000,000 per occurrence/$2,000,000 aggregate per calendar year.
$1,000,000 per occurrence/$3,000,000 aggregate per calendar year.

Tail Coverages:

Should you stop practicing or change to another insurance company, MICA guarantees availability of a limited or unlimited Reporting Endorsement known as "tail" coverage to cover subsequently reported claims.* Tail coverage must be purchased by the insured within 30 days of termination of coverage, by cancellation or non-renewal; or by termination of employment or association with the physicians insured under a master group policy.

"Tail" coverage must also be recognized when a physician reduces rating classification to offset reduced premium charges while subsequently reported claims from the higher specialty continues to occur. This is currently being accomplished on a pro-rata basis when the policy is ultimately terminated, but depends on the company's rules, rates and rating plans in effect at the time the physician's class reduction is made

Cost:

The cost of "tail" coverage will depend upon the length of time you have been insured with MICA, and will be subject to the company's rules, rates, and rating plans in effect at the time the unlimited reporting endorsement is requested.

The tail premium is quoted as a one time cost but may be paid in installments. Refer to paragraph INSTALLMENTS.

The full premium for an Unlimited Reporting Endorsement must be received by the company within twelve months following its inception date. The Unlimited Reporting Endorsement will be cancelled at the end of this twelve month period if the full premium has not been received at that time, and only premium earned for this twelve month Reporting Endorsement period will be charged in accordance with rates actuarially determined and filed with the Division of Insurance.

Retirement Benefit:

An Unlimited Reporting Endorsement (tail coverage) will be issued at no extra cost to any physician who has attained the age and years in the MICA program (as per the schedule below) and having completed five consecutive years as a MICA insured just prior to retirement:

Age	Years as MICA Insured
60	5
59	6
58	7
57	8
56	9
55	10

* The policy limits in effect at the time the Unlimited Reporting Endorsement is purchased will be applicable just as if the policy had not been cancelled or terminated and the claim had been reported during the last policy year.

CLAIMS - MADE PREMIUM SCHEDULE

Effective January 1, 1989 **

LIMITS OF LIABILITY: EACH CLAIM AND ANNUAL AGGREGATE

	1st - 5th Years	$200,000/$600.000	$500,000/$1,000,000	$1,000,000/$2,000,000 $1,000,000/$3,000,000 *
CLASS 1				
1st year rates	Jan. 1, 1989	3,087	3,598	4,364
• 2nd year renewal rates	Jan. 1, 1988	4,532	5,644	7,269
• 3rd year renewal rates	Jan. 1, 1987	7,141	9,275	12,374
• 4th year renewal rates	Jan. 1, 1986	8,027	10,504	14,098
• 5th year renewal rates	Jan. 1, 1985	8,082	10,581	14,206
CLASS 2				
1st year rates	Jan. 1, 1989	4,477	5,396	6,740
• 2nd year renewal rates	Jan. 1, 1988	7,031	8,950	11,736
• 3rd year renewal rates	Jan. 1, 1987	11,515	15,161	20,441
• 4th year renewal rates	Jan. 1, 1986	13,029	17,256	23,376
• 5th year renewal rates	Jan. 1, 1985	13,125	17,387	23,560
CLASS 2-A *				
1st year rates	Jan. 1, 1989	6,066	7,451	9,454
• 2nd year renewal rates	Jan. 1, 1988	9,886	12,728	16,840
• 3rd year renewal rates	Jan. 1, 1987	16,514	21,887	29,661
• 4th year renewal rates	Jan. 1, 1986	18,747	24,972	33,980
• 5th year renewal rates	Jan. 1, 1985	18,887	25,166	34,251
CLASS 2-B/3				
1st year rates	Jan. 1, 1989	7,655	9,506	12,168
• 2nd year renewal rates	Jan. 1, 1988	12,742	16,506	21,944
• 3rd year renewal rates	Jan. 1, 1987	21,514	28,613	38,880
• 4th year renewal rates	Jan. 1, 1986	24,465	32,688	44,584
• 5th year renewal rates	Jan. 1, 1985	24,650	32,944	44,942
CLASS 4				
1st year rates	Jan. 1, 1989	11,032	13,873	17,936
• 2nd year renewal rates	Jan. 1, 1988	18,810	24,535	32,790
• 3rd year renewal rates	Jan. 1, 1987	32,138	42,906	58,472
• 4th year renewal rates	Jan. 1, 1986	36,615	49,085	67,117
• 5th year renewal rates	Jan. 1, 1985	36,895	49,473	67,659
CLASS 4-A				
1st year rates	Jan. 1, 1989	12,422	15,671	20,311
• 2nd year renewal rates	Jan. 1, 1988	21,309	27,841	37,256
• 3rd year renewal rates	Jan. 1, 1987	36,512	48,791	56,539
• 4th year renewal rates	Jan. 1, 1986	41,617	55,837	76,395
• 5th year renewal rates	Jan. 1, 1985	41,938	56,279	77,013
CLASS 5				
1st year rates	Jan. 1, 1989	16,991	21,578	28,115
• 2nd year renewal rates	Jan. 1, 1988	29,519	38,703	51,931
• 3rd year renewal rates	Jan. 1, 1987	50,886	68,129	93,046
• 4th year renewal rates	Jan. 1, 1986	58,056	78,021	106,881
• 5th year renewal rates	Jan. 1, 1985	58,505	78,641	107,749

* PREMIUM COST IS 4 % ABOVE $1,000,000/$2,000,000 LIMITS.

CLAIMS-MADE PREMIUMS PREPARED BY MILLIMAN & ROBERTSON INC., CONSULTING ACTUARIES FOR THE MEDICAL INDEMNITY CORPORATION OF ALASKA, ARE BASED ON A FIVE-YEAR PRICING STEP FOR REPORTED CLAIMS ADJUSTED ANNUALLY FOR CLAIMS EXPERIENCE.

• RETROACTIVE DATES AND RENEWAL PREMIUMS APPLY TO 2ND THROUGH 5TH YEAR ANNUAL RENEWAL. FIRST YEAR PHYSICIANS ARE SUBJECT TO FIRST YEAR RATES. ALL POLICIES ARE RENEWED EACH YEAR ON JANUARY 1. ALL 1ST AND RENEWAL PREMIUMS ARE PRORATED SUBJECT TO THE FIRST DAY OF COVERAGE UNDER THE ORIGINAL POLICY.

** SUBJECT TO 12.6 % INCREASE (RETROACTIVE TO 1/1/89) IF MICA'S FEDERAL TAX LIABILITY HAS NOT BEEN LEGISLATIVELY RESOLVED BY 7/1/89.

ATTACHMENT C

Medical Insurance Exchange of California

(MIEC) 1989 Coverage Classification and Premium Schedule

MIEC Medical Insurance Exchange of Californi

1989 Coverage Classification and Premium Schedule

If you practice in more than one specialty, use the highest rated specialty.

CLASS	SPECIALTY
2	Administrative Medicine
2	Allergy
8	Anesthesiology
6	Assisting at Surgery
4	Cardiology, Excluding Cardiac Catheterization and Angioplasty
6	Cardiology, Including Cardiac Catheterization and Angioplasty
9	Cardiovascular Surgery
8	Colon & Rectal Surgery
4	Dermatology, Excluding Hair Transplants
6	Dermatology, Including Hair Transplants
7	Dermatology — liposuction
8	Emergency Medicine
4	Endocrinology
	Family Practice/General Practice
3	— No Surgery
6	— Less than 5% of practice from Surgery
7	— 5% or more of practice from Surgery
10	— Including Obstetrics
4	Castroenterology
4	General Preventive Medicine
8	General Surgery
8	Gynecology (Only)
8	Hand Surgery
8	Head & Neck Surgery
4	Hematology
6	Industrial Medicine
4	Infectious Diseases
4	Internal Medicine, Excluding Cardiac Catheterization and Angioplasty
6	Internal Medicine, Including Cardiac Catheterization and Angioplasty
5	Neonatology
3	Neoplastic Diseases
3	Nephrology
5	Neurology, Excluding Invasive Procedures
6	Neurology, Including Invasive Procedures
10	Neurological Surgery
4	Nuclear Medicine
10	OB-GYN
4	Occupational Medicine (Not Industrial)
5	Ophthalmology, Excluding Radial Keratotomy
7	Ophthalmology, Including Radial Keratotomy or 5% or more from Cosmetic Surgery
9	Orthopedics, Excluding Spinal Surgery and use of Chymopapain
10	Orthopedics, Including Spinal Surgery and use of Chymopapain
8	Otolaryngology
9	Otolaryngology — 5% or more from Cosmetic Surgery
2	Pathology
4	Pediatrics
8	Pediatric Surgery
3	Physical Medicine and Rehabilitation
8	Plastic Surgery
1	Psychiatry*
1	Psychiatry, Child*
2	Public Health
4	Pulmonary Diseases
7	Radiology, Diagnostic and Therapeutic
5	Radiology, Diagnostic Only
7	Radiology, Therapeutic Only
4	Rheumatology
8	Thoracic Surgery, Excluding Cardiovascular
5	Urgent Care Medicine
7	Urology

*Without ECT or drug shock therapy. With ECT or drug shock therapy, use Class 4

Partnership/Corporation Liability and Full Time Employed Physicians — 7% if all partners/shareholders and employed doctors have $500,000/1,500,000 limits; 2.5% if all partners/shareholders and employed doctors have $1,000,000/3,000,000 limits or higher. Full Time Employed Physicians must carry limits at least equal to employer. Employer will be charged a percentage of the premium charged for the employed physician's classification at employer's limits.

Secretaries, Receptionists and Bookkeepers — No charge.

Optional Coverages:

Professional premises/limited non-owned automobile liability — Covers certain liabilities for injuries sustained by the public or for damage to property of third persons at your offices. It also covers certain liabilities to injured parties arising from an employee's use of an automobile (not owned, rented or leased to you) in the course of your professional practice, up to $100,000 for bodily injury and $25,000 for property damage. Refer to the policy for coverage specifics.

LIMITS OF LIABILITY: Bodily injury, $500,000 each claim/aggregate, or $1,000,000 each claim/aggregate (to coincide with professional liability limits, but not higher than $1,000,000); Property damage, $100,000.

PREMIUM: No additional premium for premises occupied as physicians' professional offices. Clinics and other premises: refer to MIEC.

Defense coverage for miscellaneous liability

Provides up to $100,000 legal defense coverage only for alleged acts or omissions involving:

- Certain civil actions or proceedings, including a physician's acts or omissions as an officer of a national, state or local medical or specialty society;
- Alleged wrongful termination or discrimination against an employee;
- Breach of contract or other alleged misconduct in the nature of a commercial or fee dispute arising from professional practice;
- Assault, battery, false arrest or personal restraint, malicious prosecution or conspiracy arising from professional practice.

This optional coverage is fully described in Part IV of the MIEC policy and is subject to the terms and conditions of the policy and endorsements actually issued. MIEC pays 90% of legal expenses to a maximum amount of $100,000.

If you are interested in Part IV coverage, please contact MIEC for an application and premium quotation.

MEDICAL INSURANCE EXCHANGE OF CALIFORNIA

ALASKA

CLAIMS MADE PROFESSIONAL LIABILITY PREMIUM SCHEDULE

EFFECTIVE AUGUST 1, 1989

LIMITS OF LIABILITY: 500,000 EACH CLAIM / 1,500,000 ANNUAL AGGREGATE

DOCTORS COVERAGE CLASSIFICATIONS	FIRST YEAR RATES RETROACTIVE DATES: 01/01/89 OR LATER		SECOND YEAR RATES RETROACTIVE DATES: 01/01/88 - 12/31/88		THIRD YEAR RATES RETROACTIVE DATES: 01/01/87 - 12/31/87		FOURTH YEAR RATES RETROACTIVE DATES: 01/01/86 - 12/31/86		FIFTH YEAR RATES RETROACTIVE DATES: 08/01/75 - 12/31/85	
	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY
1. COVERAGE CLASS 1	2,124	531	4,172	1,043	5,304	1,326	5,728	1,432	6,220	1,555
2. COVERAGE CLASS 2	2,700	675	5,308	1,327	6,748	1,687	7,288	1,822	7,916	1,979
3. COVERAGE CLASS 3	3,472	868	6,824	1,706	8,676	2,169	9,368	2,342	10,176	2,544
4. COVERAGE CLASS 4	3,856	964	7,584	1,896	9,640	2,410	10,408	2,602	11,308	2,827
5. COVERAGE CLASS 5	4,436	1,109	8,720	2,180	11,084	2,771	11,972	2,993	13,004	3,251
6. COVERAGE CLASS 6	5,784	1,446	11,372	2,843	14,456	3,614	15,612	3,903	16,964	4,241
7. COVERAGE CLASS 7	9,640	2,410	18,952	4,738	24,092	6,023	26,020	6,505	28,268	7,067
8. COVERAGE CLASS 8	13,880	3,470	27,292	6,823	34,692	8,673	37,468	9,367	40,708	10,177
9. COVERAGE CLASS 9	19,276	4,819	37,904	9,476	48,184	12,046	52,040	13,010	56,536	14,134
10. COVERAGE CLASS 10	26,212	6,553	51,552	12,888	65,528	16,382	70,772	17,693	76,888	19,222
11. NURSE/TECHNICIAN	164	41	320	80	408	102	440	110	476	119
12. PHYSIOTHERAPIST	324	81	640	160	812	203	876	219	952	238
13. PHYS ASST/NURSE PRAC	388	97	760	190	964	241	1,044	261	1,132	283

ALASKA 500,000 / 1,500,000 LIMITS
DATE PREPARED: MARCH 29,1989
PROCEDURE: NEWPREM
USERID: KARENB

MEDICAL INSURANCE EXCHANGE OF CALIFORNIA

ALASKA

CLAIMS MADE PROFESSIONAL LIABILITY PREMIUM SCHEDULE

EFFECTIVE AUGUST 1, 1989

LIMITS OF LIABILITY: 1,000,000 EACH CLAIM / 3,000,000 ANNUAL AGGREGATE

DOCTORS COVERAGE CLASSIFICATIONS	FIRST YEAR RATES RETROACTIVE DATES: 01/01/89 OR LATER		SECOND YEAR RATES RETROACTIVE DATES: 01/01/88 - 12/31/88		THIRD YEAR RATES RETROACTIVE DATES: 01/01/87 - 12/31/87		FOURTH YEAR RATES RETROACTIVE DATES: 01/01/86 - 12/31/86		FIFTH YEAR RATES RETROACTIVE DATES: 08/01/75 - 12/31/85	
	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY
1. COVERAGE CLASS 1	2,496	624	4,908	1,227	6,236	1,559	6,736	1,684	7,320	1,830
2. COVERAGE CLASS 2	3,176	794	6,244	1,561	7,940	1,985	8,572	2,143	9,316	2,329
3. COVERAGE CLASS 3	4,084	1,021	8,028	2,007	10,204	2,551	11,020	2,755	11,972	2,993
4. COVERAGE CLASS 4	4,536	1,134	8,920	2,230	11,340	2,835	12,244	3,061	13,304	3,326
5. COVERAGE CLASS 5	5,216	1,304	10,260	2,565	13,040	3,260	14,084	3,521	15,300	3,825
6. COVERAGE CLASS 6	6,804	1,701	13,380	3,345	17,008	4,252	18,368	4,592	19,956	4,989
7. COVERAGE CLASS 7	11,340	2,835	22,300	5,575	28,344	7,086	30,612	7,653	33,256	8,314
8. COVERAGE CLASS 8	16,328	4,082	32,108	8,027	40,816	10,204	44,080	11,020	47,888	11,972
9. COVERAGE CLASS 9	22,676	5,669	44,596	11,149	56,688	14,172	61,220	15,305	66,512	16,628
10. COVERAGE CLASS 10	30,840	7,710	60,648	15,162	77,092	19,273	83,260	20,815	90,456	22,614
11. NURSE/TECHNICIAN	192	48	376	94	476	119	516	129	560	140
12. PHYSIOTHERAPIST	384	96	752	188	956	239	1,032	258	1,120	280
13. PHYS ASST/NURSE PRAC	456	114	896	224	1,136	284	1,228	307	1,332	333

ALASKA 1,000,000/ 3,000,000 LIMITS
DATE PREPARED: MARCH 29,1989
PROCEDURE: NEWPREM
USERID: KARENB

ATTACHMENT D
Arizona and North Carolina Bills

State of Arizona
House of Representatives
Thirty-ninth Legislature
First Regular Session
1989

Chapter 290
HOUSE BILL 2467

AN ACT

MAKING AN APPROPRIATION TO THE DEPARTMENT OF HEALTH SERVICES FOR THE PURPOSE OF PAYING ADDITIONAL MEDICAL MALPRACTICE PREMIUM COSTS FOR PERFORMING THE DELIVERY OF INFANTS AT CERTAIN RURAL HOSPITALS; PRESCRIBING IDENTIFICATION OF QUALIFYING HOSPITALS AND PHYSICIANS; PRESCRIBING EVALUATION OF REQUESTS FOR ASSISTANCE; PRESCRIBING LIMITATIONS, AND PRESCRIBING STUDIES AND REPORTS.

Be it enacted by the Legislature of the State of Arizona:

Section 1. Appropriation; purpose; exemption

A. The sum of one hundred ninety-five thousand dollars is appropriated from the state general fund to the department of health services for the purposes described in subsection B of this section.

B. The department shall identify areas in the state that are underserved with regard to obstetrical services. For purposes of this section, an area shall be considered underserved with regard to obstetrical services if the area satisfies any of the following:

1. Fifty per cent or more of resident live-births occur outside the city or town of residence.

2. Cities or towns where obstetric services are threatened with discontinuance.

3. Cities or towns having a population of less than ten thousand where prenatal services are not provided by a physician.

4. Cities or towns having a population of less than ten thousand where obstetric backup services for a physician are not available.

5. Cities or towns where the average number of prenatal visits are less than the state average.

C. The department shall identify those physicians who practice in areas defined in subsection B of this section who meet the following:

1. Shall have current obstetrical delivery privileges at one or more rural, non-federal hospitals.

2. Shall be a registered provider with the Arizona health care cost containment system who has established a contract for obstetrical services with at least one or more of the system's prepaid contractors.

3. The physician shall be licensed by the appropriate licensure board.

D. Family physicians who perform less than fifty deliveries per year and who are required to pay an additional premium to perform obstetrical services shall be eligible to receive an amount not to exceed five thousand dollars. Family physicians who perform more than fifty deliveries per year and who are required to pay an additional premium to perform obstetrical services shall be eligible to receive an amount not to exceed ten thousand dollars. Obstetricians who are required to pay an additional premium to provide obstetrical services shall be eligible to receive an amount not to exceed ten thousand dollars. Payment of one-half of the financial assistance identified in this section shall be contingent upon receipt of the report required pursuant to subsection F of this section. The second payment shall be paid upon receipt of the second report required pursuant to subsection F of this section.

E. Physicians seeking financial assistance shall respond to the department's notice within thirty days of receipt of such notice in a format prescribed by the department. The department shall evaluate the physician's request for financial assistance and shall classify the requests according to the city or town's need for obstetrical services and ability to meet all or at least one of the criteria specified in subsection B of this section. The highest classification shall be assigned to those cities or towns which meet all of the criteria specified in subsection B of this section. The lowest classification shall be assigned to those cities or towns which meet at least one of the criteria specified in subsection B of this section. The department shall establish contracts with those physicians whose requests are assigned the highest classification. If funds remain available, the department shall proceed in descending order to establish contracts with those physicians whose requests have been assigned a lower classification until funding is depleted.

F. The financial assistance awarded pursuant to subsection E of this section shall be used for each physician who meets the qualifications of subsection C of this section, is under contract with the department to remain in practice in the rural area for the contract year and who provides a report upon completion of one-half of the contract term and upon conclusion of the contract to the department which identifies the number of women to whom the physician has provided medical services during delivery, the ages of the women, the number of prenatal visits each woman received, the number of women who are at or below federal poverty standard, the number of Arizona health care cost containment system enrolled women served and the insurance status of the women. Contracts pursuant to this section are exempt from the requirements of title 41, chapter 23, Arizona Revised Statutes.

G. The university of Arizona college of medicine shall examine the adequacy of obstetrical services in rural underserved areas. The university of Arizona college of medicine shall develop a plan which may include the use of educational subsidies designed to overcome any identified inadequacies in the delivery of obstetrical care or other primary health care services in rural Arizona. The plan shall include recommendations regarding educational subsidies, identification of funding needs, identification of alternative funding sources and necessary legislative action to implement the recommendations. The university of Arizona college of medicine shall submit their report to the governor, president of the senate and speaker of the house of representatives by February 1, 1990.

H. The department shall submit a written report to the governor, the president of the senate and the speaker of the house of representatives on or before February 1, 1990 on the number of physicians who have applied and the number of physicians who received financial assistance provided pursuant to subsection E of this section. One year from the effective date of this section, the department shall evaluate the effectiveness of the financial assistance provided pursuant to this section and shall on or before January 1, 1991, submit a written report of its findings to the governor, the president of the senate and the speaker of the house of representatives. The report shall include recommendations regarding continuation of the financial assistance, the number of physicians who received financial assistance who plan to continue providing prenatal and delivery services in rural Arizona and legislative action necessary to improve the control, distribution and cost effectiveness of the financial assistance.

I. The appropriation made in this section is exempt from section 35-190, Arizona Revised Statutes, relating to lapsing of appropriations.

Approved by the Governor June 28, 1989.

Filed in the Office of Secretary of State June 28, 1989

organizations and their employees who distribute food to the public at no charge. Eliminates gross negligence and recklessness as grounds for civil action or criminal prosecution.

Multi-county incorporations; cities; correction NOW; Rural physicians; financial assistance (H.B. 2467) - Chapter 290

Appropriates $195,000 from the state general fund to the department of health services (DHS) to provide financial assistance to rural allopathic and osteopathic physicians. The appropriation is exempt from lapsing.

Requires the Department of Health Services (DHS) to identify areas that are underserved with regard to obstetrical services and to identify licensed physicians in those areas who have current obstetrical delivery privileges at one or more rural, non-federal hospitals and who are AHCCCS registered providers.

The financial assistance is not to exceed $5,000 for family physicians who perform less than 50 deliveries and who pay an additional insurance premium to perform obstetrical services and is not to exceed $10,000 for both family physicians who perform more than 50 deliveries and obstetricians who pay an additional insurance premium to perform obstetrical services. The financial assistance shall be made in two payments during the year upon receipt of information reported by the physicians. Financial assistance shall be determined on the basis of the area's need for obstetrical services and meeting the criteria established for underserved areas.

Requires the University of Arizona College of Medicine to develop a plan to address the delivery of health care services in rural Arizona. The report shall be submitted to the Governor, President of the Senate and Speaker of the House of Representatives by February 1, 1990.

Requires the DHS to report to the Governor, President of the Senate and Speaker of the House of Representatives by February 1, 1990 on the status of the initial distribution of the financial assistance. The DHS shall report again by January 1, 1991, on the effectiveness of the program.

Contracts with qualifying physicians are exempt from the requirements of the state procurement code.

Joint legislative committee: health care (H.B. 2478) - Chapter 216

Establishes a 23-member joint legislative committee on health care to gather and compare statistical information concerning the inability of many Arizonans to obtain health care insurance. Requires the committee to develop a written report, to be submitted to the Governor, the President of the Senate and Speaker of the House of Representatives by December 31, 1989.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1987

H D

HOUSE DRH7342-LK659

Short Title: Rural Obstetrical Care Incentive. (Public)

Sponsors: Representatives Hunter, E. Warren, and Woodard.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO THE DEPARTMENT OF HUMAN RESOURCES TO ESTABLISH A PROGRAM TO COMPENSATE FAMILY PHYSICIANS AND OBSTETRICIANS WHO AGREE TO PROVIDE PRENATAL AND OBSTETRICAL SERVICES IN COUNTIES THAT ARE UNDERSERVED WITH REGARD TO THESE SERVICES.

Whereas, there are currently 22 counties in the State which have no physicians to provide prenatal or obstetrical care in those counties, most of which are rural counties; and

Whereas, there are 20 counties in the State in which more than half of the expectant mothers must leave the county for obstetrical care because there are not enough physicians in their home county to provide obstetrical care; and

Whereas, prior to 1985 nearly 500 family physicians in North Carolina were providing obstetrical care; and

Whereas, after severe increases in liability insurance premiums, some in excess of three hundred fifty percent (350%), the number of family physicians providing obstetrical care has dropped to 189, and numerous obstetricians have dropped that part of their practice; and

Whereas, it is in the interest of the State to provide quality prenatal and neonatal care and to provide access to health care for all its citizens; Now, therefore, The General Assembly of North Carolina enacts:

Section 1. From the funds appropriated from the General Fund to the Department of Human Resources there is established a reserve of nine hundred fifty thousand dollars ($950,000) for the 1988-89 fiscal year to fund a new program to compensate family physicians and obstetricians who agree to provide prenatal and obstetrical services in counties that are underserved with regard to these services. The Division of Health Services shall adopt rules determining the counties that are underserved with respect to obstetrical care that are to be part of the program; the scope of the obstetrical services that are to be provided by a physician for that physician to be eligible to receive assistance under the program; and the amount and nature of the assistance to be provided to eligible physicians. Specific rules issued by the Division of Health Services governing this new program shall include:

(1) A physician who provides obstetrical care in a county that is designated as being underserved for prenatal and obstetrical care by the Division of Health Services will be compensated for either the difference between his premiums with obstetrical care coverage and his premiums without obstetrical care coverage, or six thousand five hundred dollars ($6,500), whichever is less;

(2) Physicians providing obstetrical care through an arrangement with their local health department shall have the option of providing the care at their offices or at the facilities of the health department obstetrical clinic;

(3) No physician shall be required to assume management of the care of any obstetrical patient if the level of care required for that patient is beyond the professional competence of that physician;

(4) Physicians eligible for payment under this program shall be licensed to practice medicine in this State;

(5) Participating physicians shall provide complete obstetrical care for covered patients including prenatal care and delivery; provided, however, physicians in a county without a facility for obstetrical delivery are still eligible if they provide only prenatal care;

(6) The liability insurance rates for obstetrical care to be used to determine compensation under this program shall be based on obstetrical premiums of $1,000,000/$1,000,000 coverage at a mature rate; and

(7) Any physician compensated under this program shall not refuse to provide obstetrical care for any patient based on the patient's economic status or ability to pay.

Sec. 2. This act shall become effective July 1, 1988.

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1989

S

S 870 ADD 4-D83

SENATE DRS7620-LK263(3.17) PRINCIPAL CLERK

Short Title: Rural Obstetrical Care Funds. (Public)

Sponsors: Senators Swain and Winner.

Referred to:

A BILL TO BE ENTITLED

AN ACT TO APPROPRIATE FUNDS TO THE DEPARTMENT OF HUMAN RESOURCES FOR THE RURAL OBSTETRICAL CARE INCENTIVE PROGRAM.

The General Assembly of North Carolina enacts:

Section 1. There is appropriated from the General Fund to the Department of Human Resources the sum of one million dollars ($1,000,000) for the 1989-90 fiscal year and the sum of two million dollars ($2,000,000) for the 1990-91 fiscal year to fund the rural obstetrical care incentive program.

The rural obstetrical care program shall compensate family physicians and obstetricians who agree to provide prenatal and obstetrical services in counties that are underserved with regard to these services. The Commission for Health Services shall adopt rules determining the counties that are underserved with respect to obstetrical care that are to be part of this program, the scope of the obstetrical services that are to be provided by a physician for that physician to be eligible to receive assistance under the program, and the amount and nature of the assistance to be provided to eligible physicians. Specific rules issued by the Commission for Health Services governing this program shall include:

(1) A physician who provides obstetrical care in a county that is designated as being underserved for prenatal and obstetrical care

by the Commission for Health Services will be compensated for either the difference between his premiums with obstetrical care coverage and his premiums without obstetrical care coverage, or six thousand five hundred dollars ($6,500), whichever is less;

(2) Physicians providing obstetrical care through an arrangement with their local health department shall have the option of providing the care at their offices or at the facilities of the health department obstetrical clinic;

(3) No physician shall be required to assume management of the care of any obstetrical patient if the level of care required for that patient is beyond the professional competence of that physician;

(4) Physicians eligible for payment under this program shall be licensed to practice medicine in this State;

(5) Participating physicians shall provide complete obstetrical care for covered patients including prenatal care and delivery; provided, however, physicians in a county without a facility for obstetrical delivery are still eligible if they provide only prenatal care;

(6) The liability insurance rates for obstetrical care to be used to determine compensation under this program shall be based on obstetrical premiums of $1,000,000/$1,000,000 coverage at a mature rate; and

(7) Any physician compensated under this program shall not refuse to provide obstetrical care for any patient based on the patient's economic status or ability to pay.

Sec. 2. This act shall become effective July 1, 1989.

Signed into law by
Arizona Governor Mofford
June 28, 1989

Senate Engrossed House Bill

ISSUED BY
JIM SHUMWAY
SECRETARY OF STATE

State of Arizona
House of Representatives
Thirty-ninth Legislature
First Regular Session
1989

Chapter 290
HOUSE BILL 2467

AN ACT

MAKING AN APPROPRIATION TO THE DEPARTMENT OF HEALTH SERVICES FOR THE PURPOSE OF PAYING ADDITIONAL MEDICAL MALPRACTICE PREMIUM COSTS FOR PERFORMING THE DELIVERY OF INFANTS AT CERTAIN RURAL HOSPITALS; PRESCRIBING IDENTIFICATION OF QUALIFYING HOSPITALS AND PHYSICIANS; PRESCRIBING EVALUATION OF REQUESTS FOR ASSISTANCE; PRESCRIBING LIMITATIONS, AND PRESCRIBING STUDIES AND REPORTS.

Be it enacted by the Legislature of the State of Arizona:

Section 1. Appropriation; purpose; exemption

A. The sum of one hundred ninety-five thousand dollars is appropriated from the state general fund to the department of health services for the purposes described in subsection B of this section.

B. The department shall identify areas in the state that are underserved with regard to obstetrical services. For purposes of this section, an area shall be considered underserved with regard to obstetrical services if the area satisfies any of the following:

1. Fifty per cent or more of resident live-births occur outside the city or town of residence.

2. Cities or towns where obstetric services are threatened with discontinuance.

3. Cities or towns having a population of less than ten thousand where prenatal services are not provided by a physician.

4. Cities or towns having a population of less than ten thousand where obstetric backup services for a physician are not available.

5. Cities or towns where the average number of prenatal visits are less than the state average.

C. The department shall identify those physicians who practice in areas defined in subsection B of this section who meet the following:

1. Shall have current obstetrical delivery privileges at one or more rural, non-federal hospitals.

2. Shall be a registered provider with the Arizona health care cost containment system who has established a contract for obstetrical services with at least one or more of the system's prepaid contractors.

3. The physician shall be licensed by the appropriate licensure board.

D. Family physicians who perform less than fifty deliveries per year and who are required to pay an additional premium to perform obstetrical services shall be eligible to receive an amount not to exceed five thousand dollars. Family physicians who perform more than fifty deliveries per year and who are required to pay an additional premium to perform obstetrical services shall be eligible to receive an amount not to exceed ten thousand dollars. Obstetricians who are required to pay an additional premium to provide obstetrical services shall be eligible to receive an amount not to exceed ten thousand dollars. Payment of one-half of the financial assistance identified in this section shall be contingent upon receipt of the report required pursuant to subsection F of this section. The second payment shall be paid upon receipt of the second report required pursuant to subsection F of this section.

E. Physicians seeking financial assistance shall respond to the department's notice within thirty days of receipt of such notice in a format prescribed by the department. The department shall evaluate the physician's request for financial assistance and shall classify the requests according to the city or town's need for obstetrical services and ability to meet all or at least one of the criteria specified in subsection B of this section. The highest classification shall be assigned to those cities or towns which meet all of the criteria specified in subsection B of this section. The lowest classification shall be assigned to those cities or towns which meet at least one of the criteria specified in subsection B of this section. The department shall establish contracts with those physicians whose requests are assigned the highest classification. If funds remain available, the department shall proceed in descending order to establish contracts with those physicians whose requests have been assigned a lower classification until funding is depleted.

F. The financial assistance awarded pursuant to subsection E of this section shall be used for each physician who meets the qualifications of subsection C of this section, is under contract with the department to remain in practice in the rural area for the contract year and who provides a report upon completion of one-half of the contract term and upon conclusion of the contract to the department which identifies the number of women to whom the physician has provided medical services during delivery, the ages of the women, the number of prenatal visits each woman received, the number of women who are at or below federal poverty standard, the number of Arizona health care cost containment system enrolled women served and the insurance status of the women. Contracts pursuant to this section are exempt from the requirements of title 41, chapter 23, Arizona Revised Statutes.

G. The university of Arizona college of medicine shall examine the adequacy of obstetrical services in rural underserved areas. The university of Arizona college of medicine shall develop a plan which may include the use of educational subsidies designed to overcome any identified inadequacies in the delivery of obstetrical care or other primary health care services in rural Arizona. The plan shall include recommendations regarding educational subsidies, identification of funding needs, identification of alternative funding sources and necessary legislative action to implement the recommendations. The university of Arizona college of medicine shall submit their report to the governor, president of the senate and speaker of the house of representatives by February 1, 1990.

H. The department shall submit a written report to the governor, the president of the senate and the speaker of the house of representatives on or before February 1, 1990 on the number of physicians who have applied and the number of physicians who received financial assistance provided pursuant to subsection E of this section. One year from the effective date of this section, the department shall evaluate the effectiveness of the financial assistance provided pursuant to this section and shall on or before January 1, 1991, submit a written report of its findings to the governor, the president of the senate and the speaker of the house of representatives. The report shall include recommendations regarding continuation of the financial assistance, the number of physicians who received financial assistance who plan to continue providing prenatal and delivery services in rural Arizona and legislative action necessary to improve the control, distribution and cost effectiveness of the financial assistance.

I. The appropriation made in this section is exempt from section 35-190, Arizona Revised Statutes, relating to lapsing of appropriations.

Approved by the Governor June 28, 1989.

Filed in the Office of Secretary of State June 28, 1989

MICA Medical Indemnity Corporation of Alaska

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

June 21, 1989

Dave Donley Representative
Alaska State House
3111 "C" Street Suite 450
Anchorage, Alaska 99503

Dear Dave,

Thank-you for spending the time on the phone discussing issues effecting medical malpractice. As you know I was anxious to discuss bills proposed by you because of a special meeting of our Board of Governors on June 21, 1989, to discuss this proposed legislation. I wanted to clarify intent to properly present them for discussion to the Board.

You, your aide, Ginger Bain, and I had discussed the sliding scale matching fund or premium subsidy during the legislative session. It is my understanding after our recent discussion that HB350 should reflect what we discussed. I questioned if the algebraic formula in the bill accomplished your purpose. You suggested we work on the details later. Your intent as I understood it is to find a way to subsidize rural physicians especially those delivering babies to maintain the availability of healthcare throughout the state.

Companion bills to this matching fund, HB349 and HB355, were also discussed. You suggested that MICA could be made exempt from premium taxes when reviewing MICA's tax status. We also discussed forgiving our loans or turning them into grants. It was my understanding that we should work over the summer with the legislative drafter amending these bills. If you have him contact me I will happy to work with him.

We also discussed the concept of an administrative system. MICA has been investigating this concept for sometime and I would like to discuss this with you at some future date when we have more time.

I know you will have a busy summer. Thanks for taking the time again to discuss this with me. I hope we can get together in the fall.

Regards.

Mary

Mary A. Pierce
Executive Director

HOUSE LABOR AND COMMERCE COMMITTEE
ALASKA STATE LEGISLATURE P.O. BOX Y, JUNEAU 99811
(907) 465-3892

April 30, 1989

M E M O R A N D U M

To: Mike Ford, Attorney
Legislative Legal Services

From: Ginger Baim, aide to
Representative Dave Donley, Chair
House Labor and Commerce Committee

Re: Bill drafting request - Medical Malpractice Matching Fund

As per our conversation last week, I am writing to ask that you prepare a bill draft(s) for introduction by the House Labor and Commerce Committee as outlined below:

1. Prepare a bill draft establishing a uniform premium tax of three percent for all lines of insurance in the state. Please speak with Paul Roller, Director of the Division of Insurance, for further information regarding current premium tax practices. Include "program receipt" language in the bill requiring the Division to separately account for the increased revenues resulting from the uniform tax so that they may be appropriated by the Legislature into the MICA Medical Malpractice Matching Fund.

2. Prepare a bill/s draft making MICA's loans into grants and requiring that MICA make an initial payment of $500,000 into the Medical Malpractice Matching Fund established under the following section. Please speak with Mary Pierce of MICA to get information regarding MICA's loan obligations and internal operating procedures.

3. Prepare a bill draft creating the Alaska Medical Malpractice Matching Fund under MICA:

   a. Draft a "findings and purpose" section:*

      - it is in the state's best interest that medical providers be insured so that victims of medical malpractice may be adequately compensated and so that providers are not at risk of financial disaster when faced with an uninsured settlement.

      - the cost of medical malpractice insurance has forced many providers to go "bare" which exposes both them and their patients to unacceptable risk; has caused providers to cease delivering necessary medical services; acts as a disincentive for medical providers to practice in Alaska.

      - Alaska has one of the lowest providers per capita ratios in the nation and it is in the state's best interest to increase the number of physicians in the state, particularly in rural areas.

- there is a particular crisis in rural areas of the state because of the high cost of medical malpractice insurance that threatens the public health and safety

- the purpose in enacting this act is to provide immediate and substantial relief to medical providers so that they can afford to purchase medical malpractice insurance while the Legislature continues to work on measures designed to reduce costs of medical malpractice insurance

b. The fund shall consist of money appropriated by the Legislature and payments by MICA into the fund.

c. MICA shall make an initial deposit into the fund of $500,000.

d. MICA shall distribute the money in the fund on a sliding scale established in "e".

e. Establish a sliding scale to reimburse medical providers for part of the amount that their annual medical malpractice premium exceeds ten percent of their gross personal annual income based on the following formula:

ANNUAL GROSS INCOME	PREMIUM	% OF INCOME	% TO BE MATCHED	AMOUNT TO MATCHED	MATCH
$100,000.	$11,000.	11	1%	$ 1,000	51%
$100,000.	$12,000.	12	2%	2,000	52%
$100,000.	$13,000	13	3%	3,000	53%
$100,000.	$14,000	14	4%	4,000	54%
$100,000.	$15,000	15	5%	5,000	55%
$100,000.	$20,000	20	10%	10,000	60%
$100,000.	$30,000	30	20%	20,000	70%
$100,000.	$40,000	40	30%	30,000	80%
$100,000.	$50,000	50	40%	40,000	90%
$100,000.	$60,000	60	50%	50,000	100%

Interpretation: If a provider earns $100,000 and pays an annual premium of $50,000 (or 50%) then the medical malpractice matching fund will pay 90 percent of $40,000.

* This should be a gradual scale, a percent at a time, so there are no "jumps"

f. EXCEPTIONS: Exceptions to the sliding scale should include a provision that:

- there will be no match for any portion of a premium that is a "surcharge".

- the fund will pay 100% of that portion of a premium that is for OBGYN coverage for providers operating in rural areas that deliver fewer than 10 babies a year or provide prenatal care for fewer

than 20 patients a year.

- the matching fund is only available to providers insured by MICA

g. Providers must submit a copy of their federal income tax filing to MICA so that their annual gross personal income may be established. MICA shall develop forms and procedures for applying for matching funds.

h. Insert a "sunset" clause ending the medical malpractice matching fund five years from its enactment with any remaining funds lapsing into the general fund.

The Committee would like a draft document to work from as soon as possible with the intent to introduce the bill prior to adjournment and to take it up in interim hearings so it can be finalized and ready to move at the beginning of next session.

Please call me at 4954 if you have any questions or need additional information.

* Feel free to clean up the language in this section and to add or delete anything you think is appropriate.

Signed into law by
Arizona Governor Mofford
June 28, 1989

Senate Engrossed House Bill

ISSUED BY
JIM SHUMWAY
SECRETARY OF STATE

State of Arizona
House of Representatives
Thirty-ninth Legislature
First Regular Session
1989

Chapter 290
HOUSE BILL 2467

AN ACT

MAKING AN APPROPRIATION TO THE DEPARTMENT OF HEALTH SERVICES FOR THE PURPOSE OF PAYING ADDITIONAL MEDICAL MALPRACTICE PREMIUM COSTS FOR PERFORMING THE DELIVERY OF INFANTS AT CERTAIN RURAL HOSPITALS; PRESCRIBING IDENTIFICATION OF QUALIFYING HOSPITALS AND PHYSICIANS; PRESCRIBING EVALUATION OF REQUESTS FOR ASSISTANCE; PRESCRIBING LIMITATIONS, AND PRESCRIBING STUDIES AND REPORTS.

Be it enacted by the Legislature of the State of Arizona:

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1. Fifty per cent or more of resident live-births occur outside the city or town of residence.

2. Cities or towns where obstetric services are threatened with discontinuance.

3. Cities or towns having a population of less than ten thousand where prenatal services are not provided by a physician.

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2. Shall be a registered provider with the Arizona health care cost containment system who has established a contract for obstetrical services with at least one or more of the system's prepaid contractors.

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D. Family physicians who perform less than fifty deliveries per year and who are required to pay an additional premium to perform obstetrical services shall be eligible to receive an amount not to exceed five thousand dollars. Family physicians who perform more than fifty deliveries per year and who are required to pay an additional premium to perform obstetrical services shall be eligible to receive an amount not to exceed ten thousand dollars. Obstetricians who are required to pay an additional premium to provide obstetrical services shall be eligible to receive an amount not to exceed ten thousand dollars. Payment of one-half of the financial assistance identified in this section shall be contingent upon receipt of the report required pursuant to subsection F of this section. The second payment shall be paid upon receipt of the second report required pursuant to subsection F of this section.

E. Physicians seeking financial assistance shall respond to the department's notice within thirty days of receipt of such notice in a format prescribed by the department. The department shall evaluate the physician's request for financial assistance and shall classify the requests according to the city or town's need for obstetrical services and ability to meet all or at least one of the criteria specified in subsection B of this section. The highest classification shall be assigned to those cities or towns which meet all of the criteria specified in subsection B of this section. The lowest classification shall be assigned to those cities or towns which meet at least one of the criteria specified in subsection B of this section. The department shall establish contracts with those physicians whose requests are assigned the highest classification. If funds remain available, the department shall proceed in descending order to establish contracts with those physicians whose requests have been assigned a lower classification until funding is depleted.

F. The financial assistance awarded pursuant to subsection E of this section shall be used for each physician who meets the qualifications of subsection C of this section, is under contract with the department to remain in practice in the rural area for the contract year and who provides a report upon completion of one-half of the contract term and upon conclusion of the contract to the department which identifies the number of women to whom the physician has provided medical services during delivery, the ages of the women, the number of prenatal visits each woman received, the number of women who are at or below federal poverty standard, the number of Arizona health care cost containment system enrolled women served and the insurance status of the women. Contracts pursuant to this section are exempt from the requirements of title 41, chapter 23, Arizona Revised Statutes.

G. The university of Arizona college of medicine shall examine the adequacy of obstetrical services in rural underserved areas. The university of Arizona college of medicine shall develop a plan which may include the use of educational subsidies designed to overcome any identified inadequacies in the delivery of obstetrical care or other primary health care services in rural Arizona. The plan shall include recommendations regarding educational subsidies, identification of funding needs, identification of alternative funding sources and necessary legislative action to implement the recommendations. The university of Arizona college of medicine shall submit their report to the governor, president of the senate and speaker of the house of representatives by February 1, 1990.

H. The department shall submit a written report to the governor, the president of the senate and the speaker of the house of representatives on or before February 1, 1990 on the number of physicians who have applied and the number of physicians who received financial assistance provided pursuant to subsection E of this section. One year from the effective date of this section, the department shall evaluate the effectiveness of the financial assistance provided pursuant to this section and shall on or before January 1, 1991, submit a written report of its findings to the governor, the president of the senate and the speaker of the house of representatives. The report shall include recommendations regarding continuation of the financial assistance, the number of physicians who received financial assistance who plan to continue providing prenatal and delivery services in rural Arizona and legislative action necessary to improve the control, distribution and cost effectiveness of the financial assistance.

I. The appropriation made in this section is exempt from section 35-190, Arizona Revised Statutes, relating to lapsing of appropriations.

Approved by the Governor June 28, 1989.

Filed in the Office of Secretary of State June 28, 1989

HOUSE COMMITTEE REPORT

(7)

Date Referred: May 6, 1989 FURTHER REFERRALS: JUDICIARY
FINANCE

Date of Committee Action: 5/7/90

The LABOR & COMMERCE Committee considered: HB 350

HOUSE BILL NO. 350 [FUNDS FOR PHYSICIAN INSURANCE PREMIUMS]
"An Act creating the Alaska medical malpractice matching fund; and providing for an effective date."

RECOMMENDATIONS:
[ ] be replaced with CS HB 350 (L+C) [ ] the same title [✓] a new title
[ ] have attached amendment(s)
[✓] do pass
[ ] do not pass
[ ] no recommendation
[ ] individual recommendations
[ ] additional referral to the judiciary Committee

ADOPTS: _____ letter of intent

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

APPROVES PREVIOUS: (Date/Dept)
[ ] fiscal note(s) _____
[ ] zero fiscal note(s) _____
[ ] zero fn/analysis _____

SIGNING DO PASS:

Finkelstein
Dave Donley Donley
Mary Sumner Sumner
Mark Boyer Boyer

SIGNING: (Check approp. column)

	Do Not Pass	No Rec	Amend
[illegible]		ttk	
Drew Lerman Lerman	Collins		X
Virginia M Collins	X		
creates more problems than it solves!			
R/C Boucher	HAM	[illegible]	
[illegible]		=	

Dave Donley
Chairman's Signature

STATE OF ALASKA
1990 LEGISLATIVE SESSION

BILL VERSION: CS HB 350 (L&C)
PUBLISH DATE: _____

FISCAL NOTE

REQUEST:

Revision Date: _____
Title: Alaska Medical Malpractice Matching Fund
Sponsor: Donley
Requestor: H. Labor & Commerce

Agency Affected: Commerce & Economic Dev.
BRU: Insurance
Components: _____

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0	0	0	0	0	0
CAPITAL	0	0	0	0	0	0
REVENUE	0	0	0	0	0	0

FUNDING: (Thousands of Dollars)

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

POSITIONS:

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

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

Prepared by: Don Koch, Chief of Market Surveillance
Division: Insurance
Phone: 465-2515
Date: 2/5/90

Approved by Commissioner: Larry Mercuilieff
Agency: Department of Commerce & Economic Development
Date: 6 Feb 90

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

LW/dg16253D/2590a

STATE OF ALASKA

OFFICE OF THE GOVERNOR

BILL ANALYSIS

DEPARTMENT	DIVISION	BILL NUMBER	SPONSOR
Commerce & Econ. Dev.	Insurance	HB 350	Donley and Gruenberg

SHORT TITLE OF BILL: An Act creating the Alaska Medical Malpractice Matching Fund; and providing for an effective date

DEPARTMENT POSITION: Neutral

PREPARED BY	DATE	COMMISSIONER'S SIGNATURE	DATE
	11/21/89		12 Dec 89

SUMMARY

OTHER AGENCIES AFFECTED BY BILL	CONSTITUENT GROUPS AFFECTED BY BILL
	Health Care Providers
ORGANIZATIONAL SUPPORT FOR BILL	**ORGANIZATIONAL OPPOSITION TO BILL**

FISCAL IMPACT: ☒ NONE ☐ FISCAL NOTE ATTACHED

BACKGROUND/LEGISLATIVE INTENT

ANALYSIS OF BILL/PROGRAM EFFECTS

See Attached

AMENDMENTS PROPOSED

5744D/112089a

PLEASE ATTACH A SEPARATE SHEET FOR ADDITIONAL COMMENTS OR ANALYSIS.

01-003 (Rev. 12/88)

ANALYSIS OF BILL/PROGRAM EFFECTS - HB 350

SECTION 1. FINDINGS AND PURPOSE.

The Legislature finds that the cost of medical malpractice insurance for some health care providers has reduced the availability of health care in Alaska and has created a situation in which there may not be adequate compensation in cases of medical malpractice because claims may be uninsured.

SECTION 2.

House Bill 350 adds a new section, AS 21.88.310, Medical Malpractice Matching Fund, to Title 21 setting up a partial subsidy of medical malpractice premiums based upon a ratio comparing the health care providers annual net income and insurance premium.

The subsidy would only be available to a health care provider insured by Medical Indemnity Corporation of Alaska (MICA). The potential for legal and constitutional challenges from other insurers providing or seeking to provide medical malpractice insurance should be considered.

The subsidy may create a situation in which it is advantageous for a health care provider to secure insurance from MICA with a government subsidy rather than secure insurance through the normal market place from an insurer whose premium, but for the subsidy, may be lower than MICA's.

Although the legislative finding is that it is in the best interest of the state that health care providers be insured in order to provide adequate compensation in cases medical malpractice (and that health care providers not be exposed to the substantial financial risks of an uninsured claim), health care providers are not required to be financially responsible in cases of medical malpractice by securing a minimum mandatory coverage for such claims.

The section provides no distinctions among the type of health care providers. A health care provider may be an individual, a partnership, or a corporation. All would appear to be eligible for the subsidy, even though their real financial condition may be substantially different. For example, a physician may be an employee as well as an owner of a health care provider which is incorporated. Either the individual physician or the corporate health care provider may secure and pay for the insurance covering the physician's practice. If the corporation appears unprofitable, even though the individual physician receives substantial income through a high salary, it may be eligible for a state subsidy. Furthermore, a physician may have substantial income from business activities related to the provision of health care but not necessarily received as income from providing health care services. A physician may have an interest in a pharmacy, laboratory, or other related business which generates substantial net income but is not directly from the physician providing health care services.

If the health care provider leases office space from a separate legal entity it has an interest in, a similar issue arises. What monies should be considered received as income from providing health care services and what monies should be considered costs for providing those services need to be clarified. It is appropriate to provide the Medical Indemnity Corporation of Alaska statutory guidance regarding these significant issues.

Section (d) of this section provides that the subsidy be equivalent of the entire medical malpractice premium attributable to obstetrics and gynecology for a physician who practices in a rural area. It appears that other health care providers involved in obstetrics and gynecology would not be recipients of a full subsidy. What constitutes a rural area is undefined. It is unclear if a physician with some patients in a truly rural area would receive the 100% subsidy upon meeting the qualification even though the majority of the practice is conducted in an urban area. Perhaps a provision defining "rural" and requirements of rural residency as well as a truly rural clientele may be appropriate.

The economic impact upon the Department of Commerce and Economic Development would be nominal because the Medical Indemnity Corporation of Alaska administers the fund. However, the liability of MICA itself is neither eliminated nor funded. For example, any litigation or legal challenges to the existence and/or operation of the fund would be funded from the corporation's general administrative budget. It may be appropriate for the Legislature to fund such costs if any are incurred. Otherwise, such expenses may represent significant contingent liabilities on MICA's balance sheet.

5744D
112089a

HB350

MICA Medical Indemnity Corporation of Alaska

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

February 23, 1990

Representative David Donley, Chairman
House Labor and Commerce Committee
State of Alaska
P.O. Box V
Juneau, Alaska 99811

Dear Chairman Donley:

I was requested in a legislative hearing on Tuesday, February 20, to supply the committee with numbers of deliveries made per physician from information gathered on a questionnaire distributed by ASMA to private practice physicians in the state.

The information follows:

Family or General Practitioners doing Obstetrics

	Fewer than 10	10-20	21-40	41-100	101-200	over 200
Anchorage *		1	3	6		
Fairbanks		4	1			
Kenai Peninsula		2	4	3	1	
South East	1	3	6	3	1	
North				1**		

* - Anchorage includes Mat-Su Valley

** - covered by Federal Government

General Surgeons (C-Section only)

	Fewer than 10	10-20	21-40	41-100	101-200	over 200
Southeast			1	1		

Obstetricians

	Fewer than 10	10-20	21-40	41-100	101-200	over 200
Anchorage			1***	2	11	3
Kenai Peninsula				1		
Fairbanks					4	

*** This physician noted that he only does 40 deliveries because CNA (his carrier) increases the rates with an increase in deliveries.

The following are the statistics I testified to during the hearings.

Total: 321 Uninsured: 48 or 15%
18% of total doctors reside in Anchorage

	Delivering or Had Been Delivering Babies	Not Doing Deliveries
Total	131	19[illegible]
Uninsured	27 or 20.6%	21 or 11%
Uninsured Located	14 - Anchorage	14 - Anchorage
	7 - Kenai Peninsula	4 - Kenai Peninsula
	2 - Fairbanks	3 - Southeast
	2 - North	
	2 - Southeast	
Stopped Coverage before 1987	6	9

% of Gross Income willing to Pay

Minimum	5%	1%
Maximum	25%	10%
Average	10%	5-10%

No Longer Delivering Babies 42 * or 32%

* - 33 doctors in the insured group were no longer delivering babies all due to cost.
- 9 doctors in the uninsured group were no longer delivering babies partially due to cost.

I hope this information proves useful. I've attached a copy of the questionnaire form that was distributed to the 616 private practice physician.

Sincerely,

Mary A. Pierce

Mary A. Pierce
Executive Director, MICA

Alaska State Medical Association

4107 Laurel Street Anchorage, Alaska 99508 (907) 562-2662 (Fax) 561-2063

December 29, 1989

Dear Colleague:

Enclosed is a survey intended to derive some needed information from Alaska physicians. As most of you know, the state medical association is taking a leadership role in trying to help the state legislature with the complicated issues surrounding tort reform and/or liability insurance. Before we can confront the legislature, we need factual data. This survey will help us gather the data regarding Alaska and match it with the larger picture of the nation and other nations of the world.

The information will be kept confidential. It is important that you realize that your name or even the coding will only be known to two or three members of the ASMA staff. Secondly, the information you provide should be flexible. You may add more data than is questioned. We want this information to be interactive so that you feel you have a part in deriving this survey. Make it as specific as you want to: give us your thoughts.

The code in the right hand corner is in three parts. The first part: G = Group, S = Solo (single practioner). The second part is the speciality code as desiginated by the American Medical Association. A copy of the list with codes is on the back of the survey form. The third part is location and that is: N = North, W = West, A = Anchorage, F = Fairbanks, SE = Southeast, and P = Kenai Peninsula. Please check the code to be sure that it does apply to you and to your practice.

I wish I could offer a prize or an incentive for completing this survey. The best I have to offer is our thanks and to tell you that you are taking part in some of the most important issues that we, as organized medicine, face today. Thank you for helping.

Cordially,

Russell A. Huffman, Jr., M.D.
President

RAH/jlw

LIABILITY INSURANCE SURVEY

1. Do you now carry medical liability insurance? _____ Yes _____ No

   If yes, how long? _____

   With what carrier? _____

   If no, when did you cancel? _____

   Do you contemplate not carrying it in the near future, i.e. within the year? ___Yes ___No

   If you don't carry insurance: Is this a philosophical choice (i.e., you don't believe in it; if you don't have it you won't get sued, etc.) _____ Yes ____ No

   Is this economic, or because of other factors that have forced your choice? ___ Yes ___ No

2. What proportion, i.e. percent, of your net income is the medical liability premium?

3. What is your opinion as to a "fair" liability premium, as either an absolute dollar figure, or percent of gross, or percent of net?

4. Is there a level of premium that you would pay, i.e. what do you think you could afford?

5. Do you deliver babies? _____ Yes _____ No

   If yes, how many per year? _____

   What premium do you pay simply for obstetrics, in excess of your liability premium without obstetrics?

   _____

   If no, was the cost of malpractice liability a major factor? _____ Yes _____ No

6. If there was an affordable insurance as described above, would you then change to doing obstetrics?

Please verify the code in the top right hand corner of this survey (as noted in the accomanying letter) and return the survey in the enclosed envelope. Thank you.