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1. Medical liability insurance is less than 1% of the total cost of health care
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Preface

We have recently celebrated the Bicentennial of the Bill of Rights of the American Constitution. That Constitution and those of the States, including Alaska, declare as fundamental, the right to jury trial and equal access to civil justice for all.

And yet today our civil justice system and the rights of injured victims and consumers are under attack. Politicians in search of solutions to such complex matters as runaway medical costs, the budget deficit and America's competitiveness in the market, oftentimes skew statistics to perpetuate unfounded myths and misconceptions about our legal system in an attempt to pin the problem on lawyers and the injured victims they represent. The multi-million dollar propaganda efforts of insurance companies and their corporate colleagues have borne fruit in biased judges, alienated juries, regressive state and federal legislative efforts, and a social environment permeated by an uncaring attitude toward the rights of the injured victims.

For more than a decade, the legislative debate over the "liability insurance crisis" has assumed that a crisis existed and focused on restriction of the rights of victims of negligence to recover fair compensation to resolve that crisis. Despite any hard data to support their claims, representatives of the insurance industry have asserted that restriction of victims' tort rights will result in lower liability insurance rates. In response to these assertions, the Alaska Legislature has adopted some of the most severe restrictions of those rights of any state in the country.

In 1989, then Speaker of the House, Sam Cotton, at the request of several fellow representatives, formed the Alaska Liability Insurance Task Force. The task force was comprised of legislators and members of medical, insurance, consumer and legal organizations familiar with li bility insurance issues. The most significant finding from the data collected by the task force was that, with some exceptions, there is <u>no liability insurance crisis in Alaska.</u>

Although there were minor differences in the conclusions reached in the various studies collected by the Liability Insurance Task Force, the general consensus was that, at best, restrictions on the rights of victims to receive fair compensation through the tort system have had only a "modest", if any, impact on liability insurance rates. More importantly, the consensus among the scholars was that state legislatures should direct their attention away from the tort system and towards alternative solutions to resolving any existing liability insurance problems.

What these studies did not address is the extent to which the public is forced to financially support those tort victims who have been disenfranchised from the legal system because of existing restrictions on tort recovery and the extent to which this gap would widen if further restrictions on tort victims' rights were enacted.

ACCESS TO JUSTICE

RIGHT OF TRIAL BY JURY -- THE FOUNDATION OF OUR SOCIETY

A fundamental guarantee in the Alaska State Constitution.

- A Guaranteed Right: Article I, Section 16 holds that in civil cases where the amount in controversy exceeds $250, the right of trial by jury is preserved.

The jury, as conscience of the community, promotes safety and equity.

- Juries Promote Safety: Over 5 million Americans serve on juries each year. As the conscience of the community, their decisions determine guilt or innocence, safety and security, life and death. Countless improvements aimed at preventing injuries and saving lives might never have occurred without trial by jury and its time-tested ability to bring about changes for the better.

- A Triumph of American Democracy: According to the consumer group, Public Citizen, "The right to collect damages through the civil justice system is one of the great triumphs of American democracy. It allows anyone, no matter how poor, to challenge the largest corporation or government agency and reclaim compensation for wrongful injuries. It forces wrongdoers to change their products and practices to prevent further injuries and avoid further liability."[1]

Critics of the jury system are the most likely to request a jury trial.

- The Ultimate Irony: The loudest critics of the jury system are insurance companies and the defendants they represent in personal injury litigation -- corporations, local government, and doctors. Ironically, the party most likely to request a jury trial in personal injury litigation is the defendant. In fact, insurers almost always demand a jury trial.

TORT RESTRICTIONS DO NOT REDUCE INSURANCE RATES

Evidence indicates that tort restrictions have no significant impact on insurance premiums or availability.

- Insurance Services Office (ISO) Says "NO REDUCTION": A 1987 ISO study determined that tort "reforms" enacted in 1986 would have little or no impact for the majority of liability claims filed with insurers.[2] In October 1986, ISO determined that

its rates would not reflect recent state tort restrictions because ISO was unable to determine any cost effect of the tort law changes.[3]

• Insurers Say "NO REDUCTION": Insurers required to provide Washington State Insurance Commissioner Richard Marquardt with evaluations of the effects of tort reforms on proposed rate filings indicated that there was no way to make such a determination, and that the 1986 law would have a minimal effect on rates. Responses from insurers in other states indicate that tort restrictions do not resolve insurance price fluctuation, reduce rates or increase availability.[4]

• Washington State Insurance Commissioner Says "NO REDUCTION": In 1987, Commissioner Marquardt told a U.S. House committee, "It is difficult, if not impossible, to pin a price tag on tort reform or to even assess accurately its effect on insurance availability and affordability. Based on our research, by the middle of 1986, general liability rates had begun to stabilize throughout the United States -- not just in the states that had adopted tort reform.[5]

• 1991 Washington Insurance Commissioner Report Says "NO REDUCTION": A 1991 report by Marquardt to the Legislature notes that insurance rates in recent years have stabilized and coverage is more readily available, however, tort changes cannot be credited as the reason. Insurers still find it difficult to quantify the impact tort reform on insurance rates. A 1989 law requiring insurers to consider investment income in setting rates was projected to have a much greater impact on insurance rates than changes in the tort system.[6]

• Best's Says "NO REDUCTION": A 1989 Best's Review article on a presentation by David B. Mathis, CEO of Kemper Reinsurance, quoted Mathis as saying, "The only way to achieve stability in the market is through adequate price levels. First of all, despite the publicity it has received, tort reform has turned out to be a non-event in terms of its impact on the big picture.".[7]

A case history -- medical negligence restrictions have little impact on rates.

• 1970 Limitations Fail: A study of medical negligence legislative limits passed in various states from 1974 to 1978 concluded that the changes, either individually or collectively, did not reduce or stabilize insurance rates.[8] Following adoption of MICRA in 1975, California's medical liability insurance premiums continued to rise (increases of 16% to 337% between 1980 and 1986.) Indiana, which adopted the most restrictive medical negligence laws of any state, had premium increases of 53% to 116% during the early 1980s.[9]

• The Crisis of 1985-1986: Despite the fact that tort restrictions had little or no effect on resolving the so-called crisis of the 1970s, a number of states passed laws restricting medical negligence actions during the mid-1980s when liability premiums began to skyrocket.

• Rate Reduction Not Due to Liability Restrictions: Nationwide, medical liability premiums began dropping early in 1989 due to a reduction in claim filings and a reduced increase in the costs to settle claims.[10]

THE LITIGATION CRISIS: DEBUNKING THE MYTHS

Personal injury cases represent a small percentage of the courts' workload.

• The courts are overburdened with over 18 million civil lawsuits filed in state courts each year: This 18 million dollar figure includes millions of routine cases such as small claims, traffic and other ordinance violation cases, domestic relations, estate and contract matters. The most recent figures from the National Center for State Courts show that the number of tort cases filed in state courts was less than half a million, or less than three percent of all state filings.

• Federal Courts: Studies of federal tort filings show lawsuits are on the decline. Over the last thirty years, tort cases as a percentage of federal civil cases dropped by nearly half, from 38.4 percent in 1960 to 20.1 percent in 1990. Product liability litigation is shrinking even faster. It has been reported that federal product liability cases, other than those involving asbestos, have been shrinking steadily in recent years, falling 40 percent between 1985 and 1990.

If there is a "litigation explosion," it is being driven by businesses suing businesses, not by personal injury actions.

• Businesses Suing Businesses: According to a University of Wisconsin study, federal litigation between corporations has increased astronomically, growing more than 1000% between 1971 and 1986.[11]

• State Courts: According to the National Center for State Courts, tort filings are not increasing at a faster rate than other major categories of civil filings. The most dramatic increases in civil cases are real property and contract cases, not torts.[12]

• Federal Courts: Nationally, between 1979 and 1987 contract cases filed in Federal District Courts more than

tripled and property cases quadrupled -- far exceeding growth in personal injury filings.[13]

Most cases are resolved prior to trial.

• Most Cases Are Settled: Only 5% of all personal injury cases filed in state courts go to trial. Complex actions, such as medical negligence cases, are more likely to go to trial than cases such as automobile personal injury (11% of medical negligence cases filed result in trials). Most cases are settled, withdrawn or dismissed prior to trial. 6% of all personal injury cases are uncontested by the defendant.[14]

LARGE JURY VERDICTS ARE UNCOMMON

Huge jury verdicts, such as million dollar verdicts, are the exception rather than the rule.

• Huge Verdicts are Rare: Huge personal injury payouts are a rarity. The largest settlements and verdicts are made to the most seriously injured victims.[15] If anything, juries are very cautious and reticent to adequately compensate injured persons. The multi-million dollar advertising campaigns of the insurance industry have used anecdotal information to make the public feel guilty about fairly compensating persons negligently injured by others.[16]

• Million Dollar Verdicts are Uncommon: According to Business Week, "Over the past 14 years in our nation of 240 million people there has been only 1,642 awards of $1 million or more. Furthermore, two-thirds of the 1,642 cases involved victims who suffered either permanent paralysis, brain damage, amputations or death."[17]

• Alaska Personal Injury Verdicts are Lower than National Verdict Average: Alaska personal injury verdicts currently average 8.1% below national verdict values.[18]

• The Most Severely Injured Persons Receive the Higher Verdicts: Product liability and medical negligence victims generally sustain more severe injuries and are more likely to receive a larger jury verdict. While the 1988 average verdict for personal injury litigation in U.S. state courts was $89,622, the highest average verdict was in the area of medical negligence ($146,831).[19]

Jury verdicts can be reduced -- the actual payout to the plaintiff may be less than the jury verdict.

• Verdicts Can be Reduced on Appeal or Settlement: The actual payout to the plaintiff is reduced after the trial verdict in about 20% of cases. The larger the verdict, the greater the likelihood that the verdict will be reduced. Of the cases where a verdict is reduced, the average actual payout is about half (53%) of the original verdict amount.[20]

"HORROR STORIES" MAKE BAD PUBLIC POLICY

Use of outrageous and atypical examples to create the impression of abuses and/or weaknesses in the civil justice system are common. Cases cited by tort critics alleging frivolous lawsuits and excessive jury verdicts are very often misleading and inaccurate.

Some examples of "horror stories":

• The Pure Fabrication -- The Lawn Mower and the Hedge Story: A widely-circulated story given in the mid-'80s as an example of our litigious society told of a man who successfully sued a lawn mower manufacturer for injuries suffered while using one of their lawn mowers to trim his hedge. In fact, this case is fictitious. It does not exist. It was a fabrication of tort reform proponents.

• Failure to Disclose All Pertinent Facts -- The Phone Booth Near the Road: In 1986, President Reagan noted that it was absurd for a California man to recover damages from a telephone company because he was in one of their booths when it was struck by a drunk driver.[21] The facts conveniently left unstated included: 1) The company knew the booth was too close to the street because it had been hit before; 2) complaints had been filed with the telephone company stating that the booth was difficult to exit because the door jammed; 3) the trial court had granted a lower court summary judgment to the company, but the California Supreme Court remanded the case to the lower court because the risk of injury was foreseeable by the telephone company; and 4) the case was ultimately settled.[22]

• Not Appropriately Placing Blame - Beware of Horse Manure: In 1987, a CBS "60 Minutes" segment focused on a lawsuit against a ladder manufacturer in which the plaintiff recovered $300,000. According to the manufacturer, the plaintiff was injured when the temperature increased from 20 to 40 degrees and the ladder slipped because it had been placed in a manure pile. "We didn't warn him about the viscosity of horse manure," said the manufacturer. To their credit, "60 Minutes" ran a follow-up segment in which a number of

alleged tort horror stories were rebuked. In re-examining the ladder story, reporter Ed Bradley noted, "Several jurors...told us the viscosity of horse manure had nothing to do with their verdict. They said they were persuaded by the plaintiff's contention that the ladder was defective, and that's why he was injured."[23]

• The Tort System Works -- The Psychic and the CAT Scan: A Philadelphia jury awarded $1 million to a woman who claimed she lost her psychic powers after undergoing a CAT scan. In fact, the woman had warned the doctor of previously having had an adverse reaction to a similar procedure. She then suffered anaphylactic shock when the procedure was performed. The jury that returned a $988,000 verdict had been instructed to disregard the woman's alleged loss of earnings because she was no longer able to "read auras." The judge found the verdict excessive and ordered a new trial. This case demonstrates that the safeguards in the process work.[24]

THE COSTS OF PERSONAL INJURY

INJURED PERSONS BEAR THE BURDEN OF PERSONAL INJURY

The injured person bears the brunt of the cost of injury.

• The Injured Person Pays First: Whether or not an injured person is reimbursed for a personal injury from another source, the initial cost of the injury is borne by the injured person and his or her family. The costs of injury include medical bills, lost wages and property damage. Personal injury often causes additional losses, such as the inability to pay bills (the house, the car), increased debt obligations and interest payments, and increased stress on family relationships. The burden of locating reimbursement for medical, wage loss, and other costs of injury falls on the injured person.

• When Defendants Don't Pay and Victims Can't, Taxpayers Do: Most personal injury cases involve significant medical and related expenses. When the victim can't pay and the defendants aren't required to fully compensate for injuries, the uncompensated cost of care is usually borne by government agencies -- in other words, by you and me as taxpayers.

• 38% of Economic Damages are Paid Out of Pocket: The total annual economic loss associated with nonfatal injuries in the U.S. is $175.9 billion. 38% of this total economic burden is not reimbursed by any outside source and is paid for out-of-pocket by those who are injured. 64% of wages lost due to injury are not

reimbursed and are borne exclusively by those injured.[25]

Personal injury liability compensation does not pay for the actual cost of injuries.

• Only a Small Number of Victims Receive Personal Injury Liability Compensation: Only 10% of all accident victims receive personal injury liability compensation. The personal injury system plays a greater role in compensating motor vehicle injury victims. Those injured in motor vehicles are more likely to receive personal injury liability compensation (31%) compared to persons injured in some other manner.[26]

CIVIL JUSTICE SYSTEM PROMOTES SAFETY IN AMERICA'S ECONOMY

TORT LAW IMPROVES AMERICAN PRODUCTS

The tort system saves lives, reduces injuries and promotes public safety.

• Product Liability and Tort Law Promote Safety: There are huge benefits of the current tort system. Businesses devote greater attention to safety. There is a heightened consumer perception that products are safer and of higher quality. Workplace and other injuries have been reduced resulting in thousands of lives saved and millions of injuries prevented. The existence of these very large benefits should give policymakers cause for careful reflection as they are pressed to weaken product liability and tort law in general. Reducing the costs of the system may reduce the benefits and leave society worse off.[27]

• The Tort System Contributes to a Competitive Society: Without a strong tort law, the ethical corporation would have a competitive disadvantage and would be tempted to put profits before public safety. The American focus on safety in conjunction with punitive damages will produce the top quality products needed to compete in the international marketplace. "Our analysis suggests that the rules of product liability make a good deal of economic sense."[28]

• Punitive Damage Awards Do Not Undercut United States Competitiveness: Perhaps nothing is more grossly exaggerated than claims about punitive damage awards, particularly in product liability cases. The most comprehensive study ever conducted on punitive damages in product liability cases -- a survey of the past 25 years -- indicated just 355 cases in the entire country. That's only ten per year for the entire country. The

median punitive damage jury award was $1.5 million, with post-trial activity sharply reducing the median amount actually paid to $250,000. The study also found that 82 percent of businesses assessed punitive damages subsequently implemented safety measures such as product recalls or improved warnings and instructions.[29]

• Harmful Products are Removed or Altered: Examples of unsafe products which have been removed from the marketplace due to the tort system include the Dalkon Shield, asbestos, flammable baby clothes, and unsafe infant formula. Examples of products redesigned to improve safety resulting from the tort system include the Ford Pinto, safety devices on machinery and childproof caps.[30]

• Product Liability Expense Adds Little Cost to Consumer Goods: A new study by the National Insurance Consumer Organization (NICO) found that product liability expenses added but a tiny amount to the cost of consumer goods. The total cost of product liability insurance amounts to 0.14 percent of the cost of the more than $1.8 trillion worth of retain sales in the U.S. in 1991. The study used insurance industry data which broke out liability premiums as a separate line item for the first time.[31]

Insurers reap benefits while projections of future losses have decreased.

• A Shift Toward Defendants: During the mid-80's judicial decisions in product liability cases nationwide shifted toward defendants. Dismissal of product claims and new legal grounds for defendants have increased during the past half decade.[32]

• Insurers Continue to Make Big Profits: While projections of future losses have decreased, insurers' reserving practices and insurance rates have not. Why? Insurers are focusing on restricting state and federal liability laws. They can't claim a need for change while recognizing reduced losses and greater profits.[33]

• Insurers Use Natural Disasters to Raise Rates: The day Hurricane Andrew rolled into Miami, a top insurance company executive for American International Group, issued a memo to regional presidents and vice presidents saying "This is an opportunity to get price increases now. We must be first and it begins by establishing the psychology with our own people."[34]

Claims that the tort system stifles innovation is a ruse.

• Dangerous Products Kept From Market for Good Reason: Tort restriction proponents claim that the threat of litigation keeps products off the market. When Consumer Union examined the list of products being held from the market, the reasons they were pulled of the market were based on valid safety concerns. For example, the Jeep CJ-7, which tends to roll over at low speeds, and an anesthesia gas machine for which the manufacturer had failed to conduct tests of the design of critical components, were on the list of products pulled from the market because the tort system was "stifling innovation".[35]

• Corporate Report Says Liability Suits Do Not Impede Competition: "The most striking finding is that the impact of the liability issue seems far more related to rhetoric than to reality...For the major corporations surveyed, the pressures of product liability have hardly affected larger economic issues, such as revenues, market share, or employee retention...Where product liability has had a notable impact - where it has most significantly affected management decision making - has been in the quality of the products themselves."[36] In addition, numerous federal agency studies of industry competitiveness conducted during the 1980's fail to mention the liability system.

The cost of liability claims is minor compared to the GNP.

• The Cost of Liability Claims v. U.S. Productivity: The total compensation from tort liability claims to persons with nonfatal traumatic injuries in the U.S. amounts to only three-tenths of one percent of the Gross National Product of the United States.[37] The total cost of all commercial liability insurance premiums in the U.S. in 1990, including general liability, automobile liability, and umbrella insurance was only $48 billion, less than 1% of the U.S. Gross National Product.[38]

MEDICAL NEGLIGENCE FACTS vs. MYTH

MEDICAL NEGLIGENCE CLAIMS -- THE REAL FACTS

Lawsuits protect the public -- the benefits outweigh the costs.

• Restrict Patients' Rights at Our Peril: One very important aspect of medical negligence litigation is the useful examination of the practice of medicine itself. Because the buyer of medical care cannot be expected to evaluate the quality of medical care, the market cannot adequately identify incompetent health care providers. "The data suggest that to eliminate or seriously restrict

a patient's right to file a malpractice claim is a step we would undertake at our peril."[39]

• Medical Negligence Standard of Care: Under Alaska law, a physician is responsible for the harm caused when the physician fails to use reasonable care in providing medical care. Other professionals, such as architects, bankers, and lawyers are also required to exercise reasonable care in their professional activities.

The frequency and severity of medical negligence claims has remained relatively constant.

• Closed Claim Study in Minnesota: The Minnesota Insurance Commissioner conducted a study of medical negligence insurance claims filed in Minnesota, North Dakota and South Dakota. The study examined all claims filed from 1982 to 1987 for the two largest medical negligence insurers in the region. 27% of the claims were closed with a payment average of $54,629; the median was zero. Only one-tenth of one percent of the claims resulted in a payment exceeding $1 million, and only 4% exceeded $100,000. Of the 3% of cases that actually went to trial, the defense prevailed in 81 percent of them. In the 20 favorable jury verdicts for the period, no pain and suffering damages were awarded. No cases involved punitive damages. A final note on the Commissioner's study: Saint Paul announced a rate cut of 25 percent on its medical malpractice premiums in Minnesota.[40]

• Unjust Payments are Rare: A new study of medical malpractice cases finds that, despite popular belief, unjustified payments are rare. The study is one of the first systematic attempts to asses the quality of care in malpractice cases and was based on 8,231 cases filed in New Jersey over the past 15 years. The data came from the state's doctor-owned insurance company and the authors contend that their findings are relevant to the nation as a whole. In concluding that unjustified payments are not the norm, the study contradicts the conventional wisdom among doctors, which is that malpractice litigation is a lottery and that verdicts often depend on the whim of jurors.[41]

• Stable Rate of Frequency: The Minnesota closed claims study identified little measurable change in claim frequency over a six year period. The frequency rate was actually greater in 1983 than in 1987 and the average payment appeared to be decreasing over the period of the study. In fact, the study concluded the "data does not substantiate the litigation explosions assertion."[42]

Liability claims without merit are not compensated, and the size of the payment is commensurate with the severity of the injury.

- The System Works: The findings of a closed claims study of obstetric claims from a large physician-owned insurance company between 1982 and 1988 indicate that non-meritorious claims were not compensated. Where a claim was paid, poor physician judgment was the primary source of error and "the size of the settlement was commensurate with the seriousness of the injury." The study concluded that "These results should help to reassure physicians who are concerned that the tort process itself is unjust. Frivolous claimants do not, as a rule, prevail."[43]

Rather than seeking large settlements, most injured patients sue for other reasons.

- Lack of Communication -- What Really Happened: According to a recent survey of 187 families who filed suits against physicians, the primary reasons for pursuing litigation were to find out what happened.[44] Poor communication by medical personnel with the patient was often cited by respondents. In addition, a prior relationship with a medical provider did not protect the provider from legal action. Physicians are finding that apologizing reduces litigation and promotes quick resolution of claims. Douglas Phillips, President of the Physicians Insurance Association of America, said that "Communicating with the patient is probably the most important aspect of loss prevention."[45]

Very few incidents of medical negligence result in a claim.

- Few Negligently Injured Patients Receive Liability Compensation: Only one in every ten incidents of medical negligence result in a liability claim, and only one in twenty-five receive compensation through the liability system.[46] Is this evidence of litigiousness -- that 70 or 80 percent of the people injured by an incompetent or negligent act do nothing about it?

Elderly and minority patients are at a greater risk of being injured by medical negligence.

- Increased Risk of Being a Negligence Victim: In a study of New York hospital discharges, patients with the highest risk of being injured due to medical negligence included elderly patients, minority patients in hospitals that treat a high proportion of minorities, patients in

government-operated hospitals and patients in non-teaching hospitals.[47]

PHYSICIAN DISCIPLINE SYSTEM DOES NOT REMOVE BAD DOCTORS

The cause of medical negligence is medical negligence -- negligent doctors committing preventable errors.

- New York Study: A Harvard study reviewed 30,121 hospital patient discharges from 51 New York state hospitals in 1984. Of these, 280 patients included an adverse event which was caused by negligence. It is estimated that 27,177 cases of medical negligence occurred in New York during 1984, resulting in 6,895 deaths and 877 instances of severe permanent disability. Only 1 in 8 injured patients filed suit and only 1 in 16 received any liability compensation.[48]

- Many Deaths are Preventable: Physicians reviewing 182 hospital deaths in 12 hospitals found that in at least 14% of the cases examined, the deaths could have been prevented. In addition, a small number of factors caused most of the preventable deaths.[49]

A small number of physicians are responsible for most of the negligence.

- Florida: 4% of the physicians practicing medicine in Florida have had 2 or more liability claims filed against them. This group is responsible for 42% of the total claims paid out from 1975 - 1986.[50]

- Illinois, Pennsylvania and Texas: 2% of all physicians practicing in Cook County, Illinois (sued 6 or more times) were defendants in 36% of the medical negligence litigation from 1973 to 1986. 57% of the physicians were not named in any lawsuit and 79% of those sued during this period were named only once or twice.[51] Studies in Pennsylvania[52] and Texas[53] had similar results.

Medical disciplinary boards do a very poor job of regulating physicians.

- New York: The New York Office of Professional Conduct takes an average of 236 disciplinary actions annually compared to an estimated 27,000 cases of medical negligence occurring each year.

- A National Disgrace: An estimated quarter million injuries and death resulted from medical negligence in American hospitals in 1988. Medical disciplinary boards in the U.S. issued an annual average of only 1,481

serious disciplinary actions against physicians from 1987 to 1990.[54]

MEDICAL NEGLIGENCE INSURANCE -- COSTS AND PROFITS

Medical liability insurance is less than 1% of the total cost of health care.

• Premiums vs. National Health Care Costs: Insurance companies argue that liability expenses are a primary factor in skyrocketing health care costs. The facts refute this allegation. In 1989, medical negligence insurance premiums in the U.S. were $5 billion.[55] National health care expenditures for 1989 were $604 billion.[56] Thus less than 1% of the national cost of health care can be attributed to medical liability premiums.

• The Texas Experience: A recent study commissioned by the Texas Hospital Association, the Texas Medical Association and the Texas Trial Lawyers Association concluded that medical liability costs -- insurance premiums and damages from lawsuits -- make up less than 1 percent of health care expenditures in Texas, consistent with national findings. The study found that reforming the medical professional liability system would have minimal cost savings impact on the overall health care delivery system in Texas.[57]

• Losses Paid vs. National Health Care Costs: Nationwide, only 43% of medical negligence insurance premiums earned -- $2.14 billion or one third of 1% of the cost of health care -- were paid out for all losses in 1989.[58] Insurers are retaining 57% of the premiums earned.

Medical negligence insurance is highly profitable for both private and physician-owned insurance companies.

• National Data: In 1989, the net profit of medical negligence insurers in the U.S. was 27.9 cents for every dollar of premium earned. From 1985 to 1989, insurers' annual average profit on medical negligence insurance was 9.2% of premiums earned.[59] Between 1985 and 1990, the net worth of medical liability insurance companies more than doubled from $835 billion to $1,691 billion.[60]

• Minnesota Study: A study of medical negligence closed claims from 1982 to 1987 by the Minnesota Commerce Commissioner found no increase in claim frequency, loss payments and loss expenses. Yet, premiums tripled resulting in a determination that St. Paul Companies --

the nation's largest medical liability insurer -- was substantially overcharging policyholders. St. Paul agreed to refund $1.5 million to physicians in Minnesota.[61]

• Physicians Sue Insurer For Excessive Premiums: In 1989, physicians in Colorado won a $4.1 million judgment against PHICO Insurance Company. The court found that the insurer created a sense of crisis and panic to justify a large premium increase.[62] Physicians in Virginia also sued PHICO for illegal conduct when the company canceled thousands of doctors policies in 1986.

• Physician-Owned Companies: An investigation by the Arizona New-Times revealed that MICA, a doctor-owned company, paid out only 30 cents of every dollar it took in. In addition, the company received a 36% rate hike in 1987. Despite a reduction in lawsuits in 1987 and its own data showing claim frequency decreasing, the company still projected increased lawsuits for 1988.

MEDICAL NEGLIGENCE RESTRICTIONS ARE NO SOLUTION

Tort restrictions will not resolve the problems of access to health care.

• The Tail Wagging the Dog: Due to the high cost of health care, a large number of Americans have no health care coverage. Blaming medical liability costs, which are less than 1% of the cost of health care, for the problem of health care access is ludicrous. Altering less than 1% of the health care costs would have no significant impact on the total cost of health care.[63]

• Reasons for Costs of Medical Care: There are numerous reasons for the increased cost of medical care, including technological advances, increases in population, increased wages as well as general and medical inflation. In a recent GAO report, medical liability costs are not even mentioned as a contributing factor of increasing health care costs.[64]

• Restrictions on Compensation Don't Work: Conventional wisdom about medical liability is not supported by the facts. Limits on verdicts and attorney's fees will not curb the incidence of litigation. Nearly 80% of the injured patients receiving liability compensation have economic losses which exceed the compensation received. This percentage is even greater for settlements. Limits on compensation will only exacerbate the current short fall.[65]

ENDNOTES

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STRAIGHT TALK ON MEDICAL MALPRACTICE

Separating Fact from Fiction

The Association of Trial Lawyers of America
February 1994

Barry J. Nace, President
Larry S. Stewart, President-Elect

STRAIGHT TALK ON MEDICAL MALPRACTICE
Separating Fact from Fiction

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STRAIGHT TALK ON MEDICAL MALPRACTICE
Separating Fact from Fiction

I. Introduction

Americans increasingly have focused their attention on a profound problem of national concern -- the escalating costs of our health care system. In 1990, the United States spent 12 percent of its gross domestic product (GDP) on health care.[1] This was more than twice as much as the country spent on national defense and nearly twice as much as it spent on education. If current trends go unchecked, the U.S. Congressional Budget Office estimates that health care spending will increase to 18 percent of GDP by the year 2000.[2]

In response to this grim forecast, federal and state policymakers have proposed solutions that would attempt to control spending and provide quality health care to all Americans. Too often, however, the resulting debate has diverged from the real issues and instead focused on America's medical liability laws.[3] The medical and insurance industries contend that America's medical liability system drives up health care costs by promoting unnecessary litigation and "defensive medicine." Therefore, they claim, we need to "reform" our liability laws to contain costs.

These false arguments do not surprise attorneys who represent health care consumers. For more than a decade, the medical and insurance industries have waged a public relations and marketing campaign to foster the perception that America is awash in medical malpractice lawsuits and outrageous jury verdicts. Neither claim is true, but the motive underlying this campaign is obvious: to promote a reordered legal system that protects the interests of health care providers and insurers.

Under the benign banner of "tort reform," the medical and insurance industries seek to:

- make it harder for injured health care consumers to bring lawsuits,
- make it tougher for consumers to prevail when they do, and
- arbitrarily limit the amount an injured consumer may recover, even after a judge or jury decides that the consumer is entitled to compensation.

These proposals are a direct assault on the Seventh Amendment's guarantee that every American has the right to trial by jury.[4] They also would interfere with the fundamental principle of federalism upon which our nation was founded.[5] The framers of our Constitution never intended that a national tort compensation scheme be established. Under federalism, the states have developed their own tort compensation schemes, including medical liability systems, taking into account the culture and history of the individual state. Differences among the states are a source of pride and symbol of strength in our legal system.

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[1] CBO, Economic Implications of Rising Health Care Costs 1 (Oct. 1992).

[2] Id.

[3] See, e.g., James S. Todd, "Reform of the Health Care System and Professional Liability," 329 New Eng. J. Med. 1733 (Dec. 2, 1993); Jessica Lee, "Malpractice: Big-ticket battle," USA Today, June 9, 1993, at 8A.

[4] The Seventh Amendment states: "In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law."

[5] The Tenth Amendment provides: "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."

The medical and insurance industries, however, have not been deterred from seeking special treatment.[6] Predictably, these industries have glossed over the alarming frequency and often catastrophic results of medical malpractice. Their proposals fail to address methods of reducing or eliminating malpractice and would have no effect on cost control. As a result, the truth about medical malpractice has been distorted in the health care debate. It is essential, therefore, to examine what effect, if any, medical malpractice litigation has on health care costs. It is equally important to understand the effects that some proposals would have on the quality of care and, ultimately, health care consumers.

To that end, this paper separates fact from fiction by assessing the impact of medical liability on health care costs and the quality of care. Further, this paper illustrates how medical liability has a positive effect on the quality of health care. Finally, the paper offers proposals to improve the quality of care by reducing the incidence of malpractice and suggests methods to contain high insurance premiums experienced in some medical specialties.

II. Medical Liability Is NOT a Factor in Rising Health Care Costs

Neither the cost of medical malpractice litigation nor so-called "defensive medicine" play any appreciable role in health care costs. In fact, malpractice litigation accounts for less than 1 percent of total health costs. Instead, focusing on malpractice liability and defensive medicine simply diverts attention from an insidious cost driver in America's health care system: self-dealing by the medical industry.[7]

A. The Impact of Medical Liability on Health Care Costs

The impact of medical malpractice litigation on total health care costs is illustrated by considering the cost of medical liability insurance. In the event of malpractice, nearly all health care providers are protected from liability by insurance. Insurers obviously do not pay out all that they collect in malpractice premiums; in fact, the medical malpractice line is very profitable.[8]

In 1991, insurers collected about $4.8 billion from health care providers for malpractice insurance.[9] These premiums equaled about 0.64 of 1 percent of national health care expenditures of nearly $752 billion in 1991.[10] Thus, medical liability insurance contributed less than 1 percent to national health care costs. In everyday terms, that amounts to 26 cents out of a $40 office visit.

Given these facts, it is not surprising that the U.S. Congressional Budget Office, an independent arm of Congress, concluded in 1992:

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[6] Ironically, American physicians and their families already are the recipients of special treatment that is not available to other citizens. "Professional courtesy," the delivery of health care at no charge or a reduced rate by physicians to other physicians and their families, is offered and supported by almost all physicians in the United States. Mark A. Levy et al., "Professional Courtesy--Current Practices and Attitudes," 329 New Eng. J. Med. 1627 (Nov. 25, 1993).

[7] See discussion of physician self-referral infra p. 7.

[8] The National Association of Insurance Commissioners reported in 1991 that medical malpractice as a line had the highest profit as a percentage of premiums. Losses paid by insurers in 1991 for medical negligence amounted to 0.31 percent (or 31 cents out of every $100) of national health care costs, according to a specialty database prepared by A.M. Best Co. For a discussion of insurer profitability, see p. 15.

[9] A.M. Best Co., Best's Aggregates and Averages 109 (1992 ed.). By comparison, Americans spent an estimated $6.4 billion on dog and cat food in 1991, or nearly $1.5 billion more than doctors spent on medical liability insurance that year. Pet Food Institute, Fact Sheet (1993).

[10] Health Care Financing Administration of the U.S. Department of Health and Human Services (1992).

> [R]estructuring malpractice liability alone would not generate large savings in U.S. health care costs.
>
> [M]alpractice premiums amount to less than 1 percent of national health care expenditures. Thus, these premiums directly contribute little to the nation's overall health care costs.[11]

Furthermore, restricting health care consumers' rights and access to courts will not eliminate the necessity of medical malpractice insurance. Since some level of malpractice insurance would be required under even the most Draconian proposals, savings achieved through such restrictions would amount to a small fraction of a demonstrably minuscule cost. Moreover, any savings achieved through lower malpractice premiums would be pocketed by the medical industry, not health care consumers.

B. State Experience with Medical Malpractice "Reform"

To understand the effect of medical liability changes on costs, policymakers should consider the states' experience with medical malpractice "reform." State efforts to control health care costs by "reforming" liability laws have failed miserably. Unfortunately, these efforts have simply cut back on health care consumers' rights and remedies.

In 1975, Indiana sought to control health care costs by enacting a total cap on damages. Injured consumers could recover no more than $500,000 (subsequently amended to $750,000) for noneconomic damages such as pain and suffering and economic damages such as medical expenses. However, this measure has done nothing to stem rising health care costs in Indiana. Between 1980 and 1990, Indiana's health care spending increased 139.4 percent -- which was even higher than the national average increase of 138.7 percent.[12] Instead, this measure has forced the most severely injured consumers to seek public assistance when their damages exceed the cap. The taxpayers of Indiana, rather than the wrongdoer, now ultimately bear responsibility for the continuing care of injured medical consumers.[13]

Likewise, California attempted to harness escalating health costs in 1975 by enacting MICRA (Medical Injury Compensation Reform Act). Among other "reforms," this law caps noneconomic damages at $250,000, eliminates the collateral source rule, allows health care providers to require patients to waive their right to a jury trial in the event of malpractice, and imposes a short statute of limitations. As in Indiana, these changes have not contained California's health care costs, which rose 143.9 percent between 1980 and 1990.[14] Again, this increase was higher than the national average. Moreover, malpractice premiums for doctors in southern California increased from 16 to 337 percent, depending upon physician specialty, between 1980 and 1986.[15]

The District of Columbia, in contrast to Indiana and California, has not enacted comprehensive changes to its medical liability laws. Nevertheless, the per capita increase in health care spending in the District between 1980 and 1990 was 108.4 percent, far below the national average of 138.7 percent.[16] Given that malpractice litigation is such an insignificant part

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[11] CBO, supra note 1, at 27.

[12] Lewin/ICF estimates as published by Families USA Foundation (Oct. 1990). Lewin/ICF is now known as Lewin/VHI.

[13] Frank Cornelius, "Malpractice Damage Caps Won't Help," Wall St. J., Oct. 13, 1993, at A23.

[14] Supra note 12.

[15] GAO, Medical Malpractice: Case Study on California 11 (Dec. 1986).

[16] Supra note 12.

of overall health care costs, it should surprise no one that states that have changed their liability laws have not succeeded in containing health costs.

C. "Defensive Medicine"

Another key element in the campaign to change America's medical liability system is the elusive concept of defensive medicine. While defensive medicine is nearly impossible to define or quantify, the medical and insurance industries assert that health care providers, fearing potential liability, order unnecessary medical tests that drive up costs.

However, defensive medicine may simply be careful medicine: using the newest testing to eliminate errors or rule out particular diagnoses; obtaining more consultations, second opinions and referrals; taking better histories, keeping better records and scheduling more follow-up visits. One study by two doctors notes:

> Standards in most specialties of medicine have not been clearly described, so that what might appear to be defensive medical practice to one clinician may, to another, be quality medical care.[17]

The American Medical Association itself concluded in 1975 that defensive medicine is good medicine.

> Generally, it is recognized that "defensive driving" is a good practice for motorists to follow. Similarly, it appears that "defensive medicine" is essentially beneficial for patients.[18]

However, after surveying the political terrain, the AMA more recently has concluded that it would be better served by decrying the costs of so-called defensive medicine.

Other members of the medical establishment remain skeptical about the very existence of defensive medicine. Dr. William Ira Bennett, former editor of the Harvard Medical School Health Letter, has written:

> A common complaint is that the costs of "defensive medicine" are also raised by the current fear of malpractice. This is hard to prove. Thanks to the abundance of health insurance, neither doctors nor patients are much deterred from spending money on excessive testing. In reality, though, failure to order a questionable test is the basis for only a small minority of malpractice judgments; most (other than slips and falls in the hospital) involve clearly wrong procedures or diagnoses.[19] (Emphasis added.)

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[17] Laurence R. Tancredi and Jeremiah A. Barondess, "The Problem of Defensive Medicine," 200 Science 879 (May 26, 1978).

[18] R.P. Bergen, "Defensive Medicine Is Good Medicine," 228 JAMA 1188 (May 27, 1974).

[19] William Ira Bennett, "The Pluses of Malpractice Suits," N.Y. Times, July 24, 1988, at 31 (Magazine). See also Harvard Medical Practice Study, Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York 10 (Executive Summary) (1990). On the issue of defensive medicine, the Harvard researchers concluded:

> Although physicians believed they practiced medicine defensively, they did not report long-term changes in their practice patterns as a result of a specific suit. Thus, it was unclear whether defensive medicine resulted from the malpractice environment or from other factors such as advances in the science and technology of medicine, changes in societal expectations as to what constitutes an appropriate level of care, or changes in Peer Review Organization (PRO), state and hospital requirements, or a combination of factors.

Nevertheless, the medical and insurance industries continually assert that defensive medicine is driving up health costs. After polling physicians, the AMA Committee on Professional Liability estimated that the cost of defensive medicine in 1983 was between $15 billion and $40 billion.[20] More recently, researchers for the AMA's Center for Health Policy Research used the physician survey to arrive at two estimates of the cost of defensive medicine in 1984: $13.7 billion and $12.1 billion.[21] It is noteworthy that these latter figures include physicians' insurance premiums, in addition to defensive medical practices. By 1991, the AMA estimated that defensive medicine cost $25 billion.[22]

Other studies, however, have concluded that the cost of defensive medicine is less than compelling. In a report released by a group advocating malpractice reform,[23] the consulting firm Lewin/VHI estimated in January 1993 that changing medical liability laws could save $35.8 billion over five years in insurance premiums and defensive medical practices.[24] Assuming the accuracy of these figures for the sake of argument, these reforms purportedly would save $7 billion a year in premiums and practice changes. Again, this is less than 1 percent of total health care costs of almost $752 billion in 1991.

The facts, when separated from fiction, led the Congressional Budget Office to conclude in 1992:

> [M]uch of the care that is commonly dubbed "defensive medicine" would probably still be provided for reasons other than concerns about malpractice. Physicians have always sought to provide patients with the best possible medical care at the lowest risks and would continue to do so even without the threat of lawsuits. Because much of this "defensive care" helps to reduce the uncertainty of medical diagnoses, it seems unlikely that physicians would change their practice patterns dramatically in response to malpractice reform.[25]

D. The Real Culprit of High Costs: Self-Referral

As long as the health care debate focuses on medical liability and defensive medicine, the medical industry can continue to deflect attention from self-referral practices that drive up health costs. As Dr. Arnold S. Relman, editor-in-chief emeritus of the New England Journal of Medicine, has observed:

> Self-referral is a prime example of the current and growing encroachment of commercialism on medical practice. . . . [T]his

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[20] American Medical Association, Report of the Board of Trustees, "Study of Professional Liability Costs" 93-102 (Dec. 1983).

[21] Roger A. Reynolds et al., "The Cost of Medical Professional Liability," 257 JAMA 2776-81 (May 22, 1989).

[22] Medical Malpractice in Health Care Reform, Nov. 10, 1993: Hearings Before the Subcomms. on Health and the Environment and Commerce, Consumer Protection and Competitiveness of the House Comm. on Energy and Commerce, 103d Cong., 1st Sess. (statement of Dr. Joseph T. Painter, President, American Medical Association).

[23] National Medical Liability Reform Coalition. In addition to the AMA and other medical associations, listed supporters of this coalition include Dow Chemical Company, the Health Insurance Association of America, the National Association of Manufacturers the Pharmaceutical Manufacturers Association, and the U.S. Chamber of Commerce.

[24] Lewin/VHI, Inc., Estimating the Costs of Defensive Medicine (Jan. 27, 1993).

[25] CBO, supra note 1, at 27.

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[24] Lewin/VHI, Inc., Estimating the Costs of Defensive Medicine (Jan. 27, 1993).

[25] CBO, supra note 1, at 27.

issue reflects the increasing tension between professional and business values.[26]

A growing body of evidence shows that a substantial purpose of "unnecessary" tests is to increase the income of physicians. The Consumer Federation of America (CFA) reported in 1991 that the most significant change in physicians' practices during the 1980s was the dramatic increase in self-dealing for ancillary medical services, including clinical laboratory tests, PAP smears, X-rays and other imaging services.[27] The CFA report found that doctors with a financial interest in a lab ordered 34 to 96 percent more tests and, as a result, their prices were 2 to 38 percent higher and total bills were 26 to 125 percent more than those of independent labs.[28]

Not surprisingly, the profit motive plays a major role in self-dealing. At least five recent studies of this practice show that self-referring doctors order testing up to eight times more often than referring doctors, and self-referring doctors' costs were up to seven and a half times higher than when outside services were used.[29]

Compounding the problem of self-referral is the fact that medical consumers lack the expertise to evaluate the necessity for testing. As a result, consumers have essentially no voice in the decision to use doctor-owned services. Moreover, it is unrealistic to expect a medical consumer, whose health is at stake, to vigorously question his or her doctor about the utility of a medical test.

Doctors, not patients, are the consumers of medical testing services. When they self-deal, doctors have interests on both sides of the same transaction, eliminating any market supply/demand check on the process. Yet, the medical industry vehemently opposes measures that would eliminate or regulate self-referral.[30] Thus, it has fallen on state legislatures to enact statutes requiring physicians to disclose their financial interest in lab facilities to patients before referral,[31] or statutes that prohibit doctors from having financial interests in testing facilities.[32] In addition, Congress has prohibited certain financial arrangements between referring physicians

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[26] Arnold S. Relman, "'Self-Referral' -- What's at Stake?" 327 New Eng. J. Med. 1522-24 (Nov. 19, 1992).

[27] Consumer Federation of America, Physician Self-dealing for Diagnostic Tests in the 1980s: Defensive Medicine v. Offensive Profits 3 (Oct. 1991).

[28] Id. at 8-9.

[29] Jean M. Mitchell and Jonathan H. Sunshine, "Consequences of Physicians' Ownership of Health Care Facilities -- Joint Ventures in Radiation Therapy," 327 New Eng. J. Med. 1497-501 (Nov. 19, 1992) (joint ventures appear to have an adverse effect on patients' access to care and increase the use of services and costs substantially); Alex Swedlow et al., "Increased Costs and Rates of Use in the California Workers' Compensation System as a Result of Self-Referral by Physicians," 327 New Eng. J. Med. 1502-06 (Nov. 19, 1992) (physical therapy initiated 2.3 times more often by self-referring physicians, while 38 percent of magnetic resonance imaging (MRIs) by self-referring doctors was found inappropriate); Bruce J. Hillman et al., "Physicians' Utilization and Charges for Outpatient Diagnostic Imaging in a Medicare Population," 268 JAMA 2050-54 (Oct. 21, 1992) (self-referring physicians ordered imaging examinations 1.7 to 7.7 times as often, and their charges were 1.6 to 6.2 times higher than doctors who did not self-refer); Jean M. Mitchell and Elton Scott, "Physician Ownership of Physical Therapy Services," 268 JAMA 2055-59 (Oct. 21, 1992) (visits per patient were 39 to 45 percent higher in joint venture facilites, while gross and net revenues were 30 to 40 percent higher in facilities owned by self-referring doctors); Bruce J. Hillman et al., "Frequency and Costs of Diagnostic Imaging in Office Practice -- A Comparison of Self-Referring and Radiologist Referring Physicians," 323 New Eng. J. Med. 1604-08 (Dec. 16, 1990) (self-referring doctors ordered imaging exams 4.0 to 4.5 more frequently and their average charges were 4.4 to 7.5 times higher).

[30] Relman, supra note 26, at 1523 (noting that six months after advising physicians to avoid self-referral, the AMA declared self-referral to be ethical as long as the patient is informed of the physician's financial interest in the facility).

[31] States that have enacted such statutes include: California, Kansas, Maryland, Minnesota, Missouri, Nevada, New Hampshire, New York, Pennsylvania, Tennessee and Virginia.

[32] Georgia, Florida and Michigan have prohibited the ownership of financial interests in testing facilities.

and clinical laboratories in response to the abuse of the Medicare system and physician reimbursements.[33]

Again, when the facts are separated from fiction, it is clear that:

- malpractice litigation is not a factor in rising health care costs;
- medical liability "reforms" enacted in the states have failed to control costs;
- defensive medicine is impossible to quantify and, in any event, contributes little to overall costs; and
- self-referral adds significant costs to health care.

III. The Incidence of Medical Malpractice

For all their concern about medical liability, the medical and insurance industries have failed to address the underlying cause of malpractice lawsuits: negligent medical care. Rather than promote improvements in quality of care or root out incompetent doctors, health care providers and insurers have diverted public attention to medical liability laws and defensive medicine.

Meanwhile, medical malpractice injures and kills consumers each day, often with little chance of being brought to public attention. Understandably, consumer groups have lined up against proposals that would cut back on citizens' rights rather than eliminate malpractice. The consumer group Public Citizen observed in November 1993:

> [M]ost attempts to address the problem of medical malpractice have been embodied in attacks on victims and their right to recover damages from negligent providers, not on solving the problem at the source -- ensuring quality care and eliminating medical negligence.[34] (Emphasis in original.)

A. The Dimensions of Malpractice

Although most health care providers are competent and well-meaning, medical malpractice in America occurs far too frequently. The Harvard Medical Practice Study found that in New York state hospitals in 1984 there were more than 27,000 negligent adverse events, including nearly 7,000 deaths and almost 900 cases of permanent disability of more than 50 percent.[35] Extrapolating these figures to the nation as a whole, medical researchers have estimated that malpractice kills more than 80,000 Americans a year and injures hundreds of thousands more.[36]

As appalling as these figures are, they actually undercount the incidence of malpractice because they are based only on in-hospital negligence. The Harvard researchers, for

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[33] 42 U.S.C. § 1395nn (1992).

[34] Medical Malpractice in Health Care Reform, Nov. 10, 1993: Hearings Before the Subcomms. on Health and the Environment and Commerce, Consumer Protection and Competitiveness of the House Comm. on Energy and Commerce, 103d Cong., 1st Sess. (statement of Pamela Gilbert, Director, Public Citizen's Congress Watch). Other consumer groups that have stated their belief that malpractice reform might further harm injured consumers, while doing nothing to rein in costs, include the American Association of Retired Persons, Citizen Action, Coalition for Consumer Rights and Center for Patients' Rights.

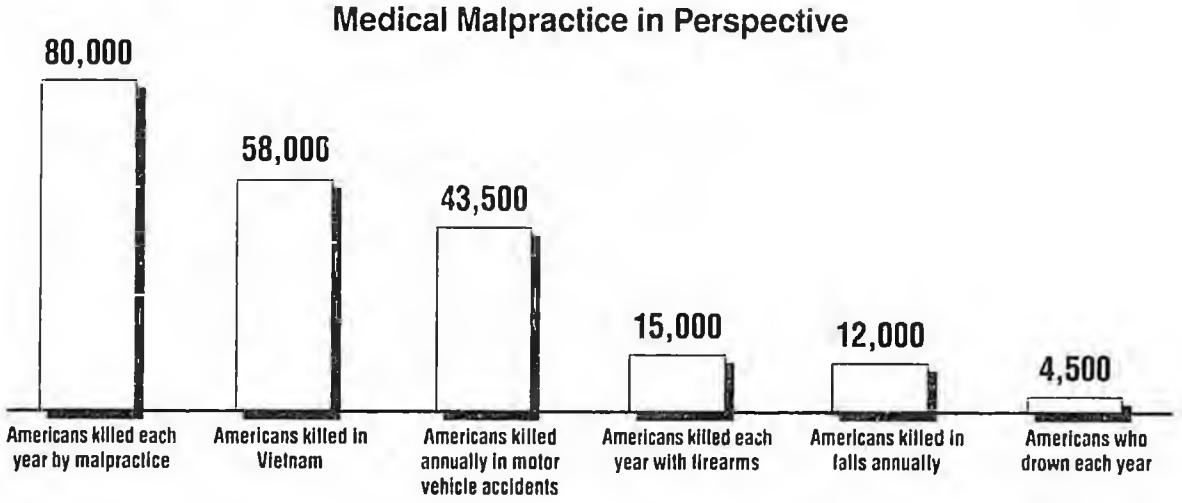
[35] Harvard Medical Practice Study, Patients, Doctors, and Lawyers: Medical Injury, Malpractice Litigation, and Patient Compensation in New York 11-1 (1990).

[36] Patricia Danzon, an economist and expert on malpractice in the United States, estimates that only about 10 percent of medical malpractice incidents result in a claim. Patricia Danzon, Medical Malpractice: Theory, Evidence and Public Policy (Harvard University Press, 1985). Thus, if the AMA is correct in estimating that 42,000 malpractice claims were filed in 1983, there would have been 420,000 malpractice incidents that year under Danzon's estimate.

example, did not attempt to quantify the extent of malpractice in clinics or private practice. Considering the number of negligence-related injuries and lawsuits actually filed, the Harvard researchers estimated that only one in eight negligently injured consumers ever brings a claim.

The 80,000 deaths annually from medical malpractice are even more chilling when put into perspective. Consider that --

- nearly 58,000 Americans were killed in the Vietnam War[37];
- about 43,500 Americans die annually in motor vehicle accidents[38];
- more than 15,000 citizens are murdered each year with a firearm[39];
- more than 12,000 Americans perish each year from falls[40]; and
- about 4,500 citizens drown annually.[41]



Unfortunately, the medical industry's only response to the incidence of medical malpractice has been to seek limits on injured consumers' remedies and access to courts. Reducing the risk of malpractice and disciplining negligent providers are not the medical industry's top priorities.

B. Hidden Malpractice

A great deal of information now exists about the quality of medical care, the competence of doctors, and mortality and morbidity rates. Yet, the institutional bias inherent in the medical industry shields most malpractice from public view. As a result, health care consumers have little basis to make informed choices about health care.

Malpractice is hidden at two levels. First, the medical culture protects its own, enforcing an informal conspiracy of silence. Early on, new health care providers learn the economic value of silence and the high price they will pay if they deviate from the norm.

Second, legislative and administrative actions shield much malpractice from ever coming to public attention. Most peer review records are not open to the public, and accreditation

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[37] Eric Schmitt, "Female Vietnam Veterans Welcomed Home," N.Y. Times, Nov. 12, 1993, at A1.
[38] National Safety Council, Accident Facts 4 (1992).
[39] FBI, Uniform Crime Reports (1992).
[40] Supra note 38.
[41] Id.

reports rarely see the light of day. The one major database that collects information on practitioner quality of care, the National Practitioner Data Bank, is off limits to health care consumers. Even doctors who want to make referrals are barred from obtaining information from the data bank.

Thus, pervasive secrecy and an almost total absence of professional discipline create an atmosphere that permits and fosters medical malpractice. Health care providers know there is little chance they will be held accountable for negligent treatment.

The rare state medical board that does act against an incompetent physician often finds that all it has done is encourage the physician to set up shop in another state. Incompetent physicians can evade disciplinary proceedings in one state by simply packing their bags and moving to another state.[42]

No one knows how many times medical boards have foisted bad doctors onto health care consumers in other states in return for a physician's promise to leave the original state. Unfortunately, if an incompetent doctor agrees to leave a state, the board often will agree to drop a complaint and the doctor's record remains unblemished.

Consumers and their families must blindly trust the medical industry as they are thrust into this information vacuum. In some instances, information about a health care provider's expertise may be obtained, but it is hard to get. More often, the competency of a doctor or hospital is not questioned until after a patient has been negligently injured.

The medical industry essentially defends secrecy on the ground that health care consumers would be misled by (i.e., are not smart enough to understand) quality-of-care data.[43] However, Americans have proved time and again that, given adequate information, they are quite capable of making extremely difficult choices. Patients who can choose between alternative courses of treatment, which they clearly have a legal right to do, can surely make more effective decisions when given access to quality-of-care information. Today, health care consumers are never given that choice.

IV. Medical Malpractice Claims Are NOT Exploding

Even though it is estimated that negligent medical treatment kills and injures hundreds of thousands of Americans each year, claims and jury awards actually are declining. In addition, studies show that juries are not biased toward plaintiffs nor do they render unjustified awards.

A. The Number of Medical Malpractice Claims

Over time, medical malpractice claims should increase as more Americans have access to health care. This is because:

- the delivery of care becomes more efficient and doctors can treat more patients daily;
- medical learning and technology advance so that doctors are held to a higher standard of care (i.e., doing nothing or too little breaches the applicable standard of care); and
- the population ages, resulting in an increased need for care.

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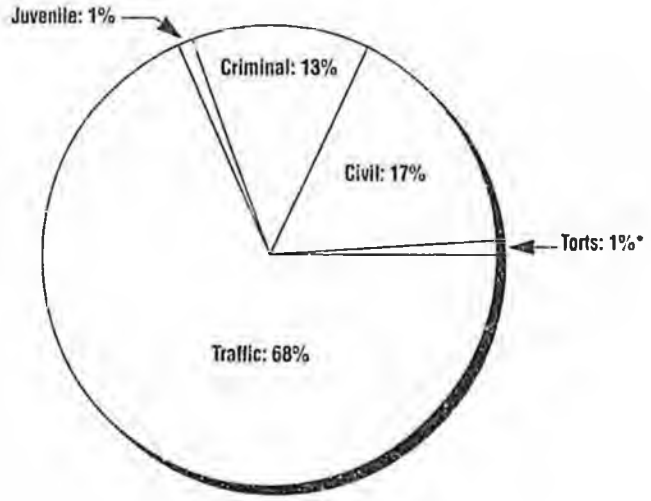
[42] See, e.g., Sandra G. Boodman, "What You Can't Know About Your Doctor," Wash. Post, Sept. 14, 1993, at 11 (Health Section); Charlotte L. Rosenberg, "How Bad Doctors Dodge Discipline," 62 Med. Econ. 240 (Mar. 18, 1985).

[43] Boodman, supra note 42. (This report notes that the AMA's House of Delegates has voted to seek the abolition of the National Practitioner Data Bank.)

Nevertheless, independent studies show that medical consumers do not bring dubious claims and, in general, are reluctant to file lawsuits against health care providers. The Harvard Medical Practice Study estimated that only one in eight negligently injured patients ever brings a claim.[44] The number of claims each year barely amounts to half of the deaths attributable to medical negligence and constitutes a very small percentage of the total injuries.[45] Thus, concluded the Harvard researchers: "[W]e do not now have a problem of too many claims; if anything, there are too few."[46]

1989 Trial Court Filings



* Tort filings accounted for about 950,000 cases or less than 1% of total filings of 98,464,661.
Sources: National Center for State Courts, 1989; Deborah R. Hensler the RAND Institute for Civil Justice

Rather than increase, the number of malpractice claims has dropped at an average annual rate of 8.9 percent since 1985.[47] The AMA reported in 1992:

> Claim frequency for all physicians was 7.7 claims per 100 physicians in 1990, as compared with 7.4 per 100 in 1989. While the claims rate did increase between 1989 and 1990, that increase was not statistically significant. In general, the results indicate a leveling off in the claims rate in contrast to the increases of the early- and mid-1980s.[48] (Emphasis added.)

Likewise, the Minnesota Department of Commerce, in a comprehensive analysis of all closed claims filed in Minnesota, North Dakota and South Dakota, found that the frequency of claims had decreased between 1982 and 1987. That study concluded:

> It would appear . . . that the data does not substantiate the litigation explosion asserted. Claim frequency has not changed measurably

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[44] See also Stephen Daniels, The Shadow of the Law: Jury Decisions in Obstetrics and Gynecology Cases 7 (American Bar Foundation Working Paper No. 8806, 1989) (estimates that only one in 25 negligently injured patients ever brings a claim); Deborah Hensler, Compensation for Accidental Injuries in the United States 55 (RAND Institute for Civil Justice, 1991) (estimates that one in 10 injured consumers seeks compensation from the tort liability system).

[45] The AMA estimated that there were 42,000 malpractice claims in 1983, compared to the estimated 80,000 deaths each year that are attributable in part to medical negligence.

[46] Harvard Medical Practice Study, supra note 35, at 11-4.

[47] Socioeconomic Characteristics of Medical Practice, Medical Professional Liability Claims and Premiums, 1985-1990, 23 (American Medical Association, 1992). In addition, the National Center for State Courts reported a drop in malpractice suits in the 1980s.

[48] Id.

> in the last six years. The 1987 frequency rate is actually less than the 1983 rate. . . . Average payments actually appeared to be decreasing over the period of study.[49]

Despite a decrease in claims frequency, the Minnesota study noted, physicians paid about three times more for malpractice insurance in 1987 than in 1982.[50]

Another myth that evaporates under even minimal scrutiny is that indigent patients are more likely to sue for medical malpractice than patients with greater economic resources. The General Accounting Office (GAO) found in 1993 that poor patients actually bring fewer claims than the general population and that awards to indigents "account for a relatively small share of total hospital malpractice losses."[51]

A more recent study corroborates the GAO finding. It concluded that poor and uninsured patients are "significantly less likely to sue for malpractice. . . ."[52] The authors noted that their results suggest that proposed legislation shielding physicians who serve the poor from malpractice suits should be reconsidered.

B. Jury Awards

Contrary to the assertions of the medical and insurance industries, malpractice claims seldom result in jury trials. In fact, most studies conclude that 10 percent of claims or less are tried.[53] Injured consumers receive compensation through negotiated settlements agreed to by both sides in about 50 percent of the remaining cases. No compensation is received by plaintiffs in 40 percent of cases.[54] Of the 10 percent of cases that go to trial, the evidence shows that (1) juries are not biased against doctors and (2) awards are not unjustified or out of control.[55]

Plaintiffs often must overcome several hurdles, not the least of which is jurors' generally favorable view of health care providers. If anything, plaintiffs bear an extra burden in malpractice cases because jurors are suspicious of plaintiffs' motives for suing and scrutinize their actions more closely than those of defendants. Further, plaintiffs generally begin from a weaker position since health care providers and insurers have vast resources. At least one court has observed that medical malpractice litigation is "galaxies apart" from typical cases and

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[49] Minnesota Department of Commerce, Medical Malpractice Claim Study, 1982-1987, 17 (1989).

[50] Id. at 31.

[51] GAO, Medicare/Medicaid Beneficiaries Account for a Relatively Small Percentage of Malpractice Losses 2 (Aug. 1993).

[52] Helen R. Burstin et al., "Do the Poor Sue More? A Case-Control Study of Malpractice Claims and Socioeconomic Status," 270 JAMA 1697 (Oct. 13, 1993).

[53] See, e.g., Mark I. Taragin, "The Influence of Standard of Care and Severity of Injury on the Resolution of Medical Malpractice Claims," 117 Annals Internal Med. 780 (Nov. 1, 1992) (about 12 percent of claims studied went to jury trial); Neil Vidmar, "The Unfair Criticism of Medical Malpractice Juries," 76 Judicature 118 (Oct.-Nov. 1992) (about 10 percent of claims were eventually tried by a jury); Michael J. Saks, "Do We Really Know Anything About the Behavior of the Tort Litigation System -- and Why Not?" 140 U. Pa. L. Rev. 1147, 1212-13, 1226 (Apr. 1992) (fewer than 10 percent of medical malpractice cases are tried); Brian Ostrom et al., "What Are Tort Awards Really Like? The Untold Story from the State Courts," 14 Law & Pol'y 77 (1992) (authors conclude that only 9.8 percent of all medical malpractice claims go to trial); Minnesota Department of Commerce, Medical Malpractice Claim Study, 1982-1987, 31 (1989) (less than half of 1 percent (0.5) of all claimants were awarded damages by a jury, while the likelihood of receiving any compensation was about 25 percent).

[54] Vidmar, supra note 53, at 118.

[55] Neil Vidmar, "Empirical Evidence on the Deep Pockets Hypothesis: Jury Awards for Pain and Suffering in Medical Malpractice Cases," 43 Duke L. J. 217 (Nov. 1993) (the reputation of juries for reaching into the perceived deep pockets of health care providers and giving excessive awards for pain and suffering is not warranted).

attorneys who represent medical consumers shoulder a heavy burden.[56] It is not surprising, then, that defendants win the majority of the malpractice cases.[57]

In addition, health care consumers do not benefit from large, unwarranted jury awards. The facts, when separated from the fiction, show that the median award -- which accurately reflects system-wide results -- is far less than the anecdotal claims of the medical and insurance industries. Moreover, awards are generally consistent with severity of injury. A New Jersey study showed that the defensibility of the case and not the severity of the injury was the predominant factor in whether any payment was made.[58] The authors concluded: "Our findings suggest that unjustified payments are probably uncommon."[59]

V. Medical Liability: A Force for Quality Health Care

By neglecting to police health care providers, the medical industry has failed to ensure quality health care. State medical boards, which are underfunded and understaffed, have not protected the public from negligent providers. Thus, without appropriate oversight, it has fallen on America's medical liability system to deter negligence.[60] Medical liability, through the civil justice system, has held bad doctors accountable for their mistakes and forced the medical industry to recall or improve the safety of dangerous products and bad drugs. Nevertheless, the medical industry continually pushes for liability "reforms" that would reduce the only effective deterrent to negligence.

State medical boards have failed to discipline negligent doctors. While over the years disciplinary actions -- license revocation, suspension and probation -- have increased, they actually have decreased proportionally due to the increase in number of doctors. In 1991, about 2,000 of the nation's 615,000 licensed physicians -- less than half of 1 percent -- were sanctioned by state medical boards.[61] While the Harvard Medical Practice Study found 27,000 negligent adverse events in one year in New York hospitals, that state's Office of Professional Medical Conduct averaged only 236 disciplinary actions a year between 1986 and 1990.[62] Many of the doctors who were disciplined were not even sanctioned for negligence, but for insurance fraud or falsifying records.

In addition, the AMA acknowledges that 30,000 to 40,000 physicians are impaired by alcohol or drugs.[63] Yet, only about 200 doctors lose their licenses a year and that includes those

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[56] Baker v. Varela, 416 So. 2d 1190 (Fla. Dist. Ct. App. 1982).

[57] See, e.g., Vidmar, supra note 53, at 118 (in cases that were tried, juries ruled in favor of plaintiffs 20 percent of the time); Taragin, supra note 53, at 782 (for the small number of cases in which there was a jury verdict, only 24 percent resulted in payment to the plaintiff).

[58] Taragin, supra note 53, at 783.

[59] Id. at 784.

[60] On the deterrent effect of medical liability, economist and researcher Patricia M. Danzon has stated: "The advantage of the tort system is that it provides a continual, ongoing system of 'regulation by incentives.' And it does not rely on enforcement by the medical profession which, like any other profession, is notoriously reluctant to police its own members." Testimony of Patricia M. Danzon, presented to the Committee on Labor and Human Resources, U.S. Senate, July 10, 1984.

[61] Boodman, supra note 42. See also Sidney Wolfe et al., 10,289 Questionable Doctors 8 (Public Citizen Health Research Group Report, Sept. 1993) (only 1,974 doctors out of 623,000 nationwide were disciplined in 1992).

[62] Kevin Sack, "More Malpractice Than Lawsuits, New York Medical Study Suggests," N.Y. Times, Jan. 29, 1990, at A1.

[63] Harvey F. Wachsman, "Doctors Who Maim and Kill and Get Away with a Wink and a Smile," N.Y. Times, Aug. 25, 1989. According to Dr. Arnold S. Relman, editor-in-chief emeritus of the New England Journal of Medicine: "20,000 physicians . . . for one reason or another probably ought not to be practicing medicine. They are either alcoholics, drug addicts, senile, criminals, or simply incompetent physicians." Richard Greene, "Quackus tyrannus," Forbes, Oct. 5, 1987, at 67.

who commit fraud or felonies.[64] On average, only 3.44 serious disciplinary actions are taken for every 1,000 doctors.[65]

When state medical boards do act, their investigations take years to complete. All the while, negligent doctors continue to treat patients. The actions of state boards also can have the unintended effect of spreading medical incompetence to other states by encouraging doctors to flee to avoid discipline.[66] A General Accounting Office study of 181 doctors whose licenses were to be revoked in Michigan, Ohio and Pennsylvania between 1977 and 1982 found that 33 simply set up shop in another state.[67] Some state boards have even agreed to dismiss a complaint in return for the doctor's promise to leave or quit practicing.

In this void of effective regulation, America's medical liability system stands alone as a check on the quality of care. As noted by one commentator in Hospital Practice:

> It is sad but true that many physicians practice more carefully than they did in the past because they have one eye on the potential litigant. . . . If the courts and insurance companies and the fear of malpractice become the most important disciplinary weapon in medicine -- distasteful as the idea may be to physicians -- so be it.[68]

Even the AMA has acknowledged the beneficial effect of medical liability on improving the quality of care.

> For all of its ills, the tort system's fault-based standard of care has prompted hospitals, medical societies and, most notably, physician-owned insurance companies to become very active in a variety of endeavors to reduce the risk of patient injuries.[69]

VI. The Need for Malpractice Insurance Reform

The root of the medical industry's push for liability "reform" is the cost of medical malpractice insurance. Premiums for high-risk specialties such as obstetrics and neurosurgery are frequently cited as examples.

Without question, some specialties pay very high premiums. However, this insurance issue is unrelated to malpractice claims. Even though some high-risk specialties have been hit with large premium increases, the cost of malpractice insurance has remained fairly constant at less than 1 percent of total health care costs. In the last few years, the cost of malpractice insurance actually has dropped. For example, malpractice premiums declined 3.4 percent (or $4.8 million) in 1991, and dropped 7.6 percent between 1989 and 1991.[70] It is noteworthy that this decline has occurred in states that have not changed their medical liability laws as well as in states that have.

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[64] Wachsman, supra note 63.

[65] Public Citizen Health Research Group, Comparing State Medical Boards (Jan. 1993).

[66] Rosenberg, supra note 42.

[67] Id.

[68] Robert S. Derbyshire, "Malpractice, Medical Discipline and the Public," 19 Hosp. Prac. 209, 216 (Jan. 1984). See also William B. Schwartz and Neil K. Komesar, "Doctors, Damages and Deterrence: An Economic View of Medical Malpractice," 298 New Eng. J. Med. 1282 (June 8, 1978) ("By finding fault and assessing damages against the negligent provider, the [civil justice] system sends all providers a signal that discourages future carelessness and reduces further damages.").

[69] Liability Wk., Mar. 5, 1990 (statement of Dr. James Todd, executive vice president of the American Medical Association).

[70] Best's Review, "Medical Malpractice," 30 (Dec. 1992).

Even with this decline in premiums, insurers' profits have soared. The National Association of Insurance Commissioners (NAIC) recently examined profitability by looking at premiums earned, losses incurred and return on insurers' net worth. For the medical malpractice line, the most recent NAIC figures show $4.86 billion in direct premiums earned in 1991, resulting in a total profit equal to 29.2 percent of the direct premiums earned (or $1.4 billion), and a 15.9 percent return on net worth (or $773 million). According to NAIC, the total investment gain in 1991 was $1.88 billion. Indeed, medical malpractice as a line has the highest profit as a percentage of premiums at 29.2 percent of direct premiums earned, with the next highest percentage being 15.6 percent realized by other liability lines.[71]

Some high-risk medical specialists continue to experience outrageous premiums. Nevertheless, the answer to this problem is not to restrict the rights of injured consumers, but to address the following problems in the insurance industry:

A. Skimming of Risk. Even though competing insurers may have nearly equal shares of the market, they have different percentages of associated risk. Doctor-owned companies set up during the insurance "crisis" in the 1970s were insurers of last resort. They insured doctors who could not obtain insurance from for-profit carriers. Consequently, doctor-owned carriers may have, for example, 50 percent of the market in premiums, but a much higher share of risk. Meanwhile, the for-profit carrier may have 50 percent of the market, but a much smaller percentage of risk. This tactic, known as "skimming," results when for-profit carriers keep the least risky groups or individual doctors for their own client base.

A way to solve this problem is to put all doctors into a unified pool from which all malpractice insurers could write insurance based on their willingness to accept a proportional share of risk. If doctors in this unified pool were risk-rated by a neutral agency (i.e., the state insurance department), insurers could be required as a condition of licensure to take a percentage of higher-risk doctors in the pool roughly equivalent to their share of the entire medical malpractice market.

Under the "two-tiered" system now in place, for-profit carriers earn a substantial income and saddle the doctor-owned companies with too much risk for their share of premiums.

B. Proliferation of Risk Categories. A related problem that boosts malpractice premiums is insurers' practice of dividing doctors into too many risk categories. This has resulted in some specialties (e.g., obstetrics and neurosurgery) paying huge malpractice premiums, while other providers pay very low premiums.

Malpractice underwriters have so fine-tuned the risk by the type of medicine a doctor practices that they may have unwittingly destroyed the cardinal rule of insurance -- spreading the risk. In many states, underwriters have subdivided the medical community into as many as 12 to 19 different specialties. Because of this proliferation of risk categories, there are too few doctors in many of the specialty pools, such as neurosurgery. This is particularly true in states where there is not a large physician population. Since negligence associated with neurosurgery or obstetrics often results in a lifetime of continuing care, the cost of such injuries is extremely high but is spread among only a small pool of doctors in the specialty pool.

The solution is to return risk categories to the way they were originally set up. When there were only three or four categories, underwriters could put a doctor in high, medium

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[71] National Association of Insurance Commissioners, Report on Profitability by Line, by State (Dec. 1992).

or low risk. By dividing the pool of doctors into a few groups, each pool has sufficient numbers to allow the concept of insurance -- spreading the risk among many insureds to permit affordable premiums -- to work. This will not increase the total premium dollars collected, but it will reallocate what certain classes of doctors pay.

If risk categories are reduced, specialists will see their premiums drop dramatically, while general and family practitioners will experience a modest increase. However, this will reflect the changing pattern of medicine over the past 20 years. Today, the general or family practitioner accepts little or no risk in his or her practice. He or she refers risky patients to a medical specialist who has little in-depth contact with patients. So long as the support system of specialists exists to take on the higher-risk procedures, the general practitioner ought to be willing to subsidize a slight change in malpractice premium allocation. Such a change permits the general practitioner to continue to access a specialized medical opinion in the high-risk case.

Medical associations do not like the idea of reallocating malpractice premiums because it is a potentially divisive issue within the medical community. Nevertheless, such a plan offers the best chance to alleviate the high premiums that certain medical specialists are now forced to pay.

C. Lack of Experience Rating. When an insurer writes malpractice insurance, it does not consider the claims experience of the individual doctor. By comparison, a poor automobile driver will pay a higher rate, which takes into account his or her accident and driving record. Bad doctors are not charged higher rates, and good doctors receive no insurance break because of their competence. Lack of experience rating of malpractice premiums is unfair to good doctors and untenable.

Since a few doctors often are responsible for a large share of malpractice claims paid,[72] insurers could deter malpractice by charging higher premiums to those most responsible for losses.

This proposal not only makes sense, but also is good public policy. It is long overdue. Basing premiums on claims experience will benefit medical consumers by deterring malpractice and encouraging good medicine.

D. Overreserving. Because medical malpractice claims generally take a long time to resolve, insurers establish reserves to cover their estimated future losses. Insurers label reserves as liabilities, but reserves are held and invested until claims and claim expenses are paid.

Insurers primarily base estimated future losses on historical loss patterns. Each year, estimates are adjusted when actual losses are compared to the estimated loss. If the income from the investment of reserves is included in calculating the annual change in the industry's medical malpractice reserve estimates, insurers overreserved by $1.4 billion between 1982 and 1991.[73]

This is not surprising when you consider how little insurers pay out in claims compared to the amount they receive in premiums. When annual premiums collected are

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[72] See, e.g., Testimony of Blaine F. Nye from public meeting entitled "Academic Task Force for the Review of the Insurance and Tort Systems" 169 (June 11, 1987) (less than 4 percent of doctors practicing in Florida in 1986 were responsible for approximately 45 percent of paid claims to injured consumers); Miller et al., Medical Malpractice: Crisis of Litigation or Crisis of Negligence? (Health Resources, Inc., March 18, 1987) (less than 2 percent of all physicians practicing in Cook County, Illinois, were defendants in 36 percent of malpractice claims filed between 1972 and 1986).

[73] A.M. Best Co., Casualty Loss Reserve Development Series -- Medical Malpractice (1992).

compared to actual annual losses paid, medical malpractice insurers paid out an average of only $45.88 for every $100 in premiums collected between 1979 and 1991.[74]

VII. Restricting Patients' Rights Is No Solution

In the current debate over health care, the medical and insurance industries are once again pushing for changes to medical liability under the banner of "tort reform." But when fact is separated from fiction, these "reforms" would: (1) make it harder for injured medical consumers to bring lawsuits, (2) make it tougher for consumers to prevail when they do, and (3) arbitrarily limit the amount an injured consumer may recover, even after a judge or jury decides that the consumer is entitled to compensation.

The medical and insurance industries' "reforms" are not intended to help consumers or improve the system, but rather to shield health care providers from responsibility for their negligent acts. As one commentator has noted, most of the empirical data on the medical liability system

> suggest[s] that the reforms that have generally been proposed would advance none of the goals of the malpractice tort system and would, in fact, exaggerate the system's most fundamental shortcomings (less compensation, larger gaps between losses and compensation) and weaken the one thing it may get right (deterrence).[75]

Proposals that would do nothing to contain costs or improve the quality of care but which would restrict injured consumers' rights are:

A. Federalization of Medical Malpractice. America has always celebrated its great diversity. Our forebears recognized that the norm in one area may be perceived as unusual in another. As a result, they balanced state and federal power, and secured states' rights in the Tenth Amendment to our federal Constitution. Tort law, of which medical liability is a part, has always been a state issue and should remain so. The federal government should not become the arbitrator of what historically has been a matter of state right.

B. Caps on Damages. Arbitrarily capping damages is unjust and further injures those who have had the misfortune of being severely injured since their damages are most likely to exceed the cap. As this paper has shown, damage caps have done nothing to control health care spending in California and Indiana. Meanwhile, a jurisdiction that has not enacted caps -- the District of Columbia -- has seen its health care costs increase at a rate below the national average. Further, damage caps permit a negligent wrongdoer to evade accountability for his or her acts. Ultimately, taxpayers must make up the difference when an injured consumer's damages exceed the cap.

C. Alternative Dispute Resolution (ADR). In its simplest form, ADR can expedite litigation by providing a process for earlier settlements while still allowing a case to proceed unfettered in court if a party is dissatisfied with the result. In that sense, increased use of ADR can be beneficial, and ATLA supports programs such as court-controlled mediation and voluntary

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[74] A.M. Best Co., Experience by State (by Line) (1992).

[75] Michael J. Saks, "Malpractice Misconceptions and Other Lessons About the Litigation System," 16 Just. Sys. J. 7 (1993).

arbitration. But many ADR proposals are promoted as substitutes for trial by jury, contain coercive penalties designed to force settlements or postpone the right to proceed in court until ADR has been completed. These forms of ADR are unfair, costly and interfere with the right of every American to have access to courts.

D. Mandatory Periodic Payments. Defendants who have been adjudicated as negligent should not be permitted to keep the plaintiff's compensation and dictate periodic payments. This only results in a windfall for defendants, since they are able to invest and earn income on the unpaid balance of an award. The injured consumer should receive this benefit. Moreover, there should never be any delayed payment without full posting of security to ensure future payments.

E. Abolition of the Collateral Source Rule. Permitting defendants and insurers to receive a windfall by requiring an injured patient to offset separately purchased benefits against an award turns the justice system on its head. The medical and insurance industries charge that plaintiffs "game the system" by receiving compensation in the form of an award and privately purchased insurance, i.e., a "double recovery." However, very few plaintiffs receive double recoveries. Further, there is no reason to benefit a wrongdoer simply because an injured consumer had the foresight to secure benefits from a collateral source.

F. Caps on Plaintiffs' Attorney Fees. Limiting plaintiffs' attorney fees is a Trojan horse intended to prevent injured medical consumers from retaining an attorney in the first place. Moreover, limiting plaintiffs' attorney fees while permitting defendants to spend unlimited sums on legal representation is patently unfair to health care consumers. This proposal attempts to stack the deck in favor of defendants.

VIII. Proposals to Improve the System

The Association of Trial Lawyers of America has never opposed change that will protect patients' rights. Thus, we advocate:

A. Improved Quality and Safety of Medical Care. The cause of medical malpractice is malpractice. Lawsuits would be greatly reduced if doctors would clean up the profession and drug companies would stop putting profits ahead of patient safety. State medical boards need to be strengthened. Performance audits and recertification for doctors, together with stronger regulation of hospitals, should be required.

The walls of secrecy should be torn down so that consumers will have meaningful access to reliable information concerning the quality of care -- particularly the National Practitioner Data Bank and peer review results. In this way, traditional market forces can weed out incompetent and dangerous health care providers.

Arbitrary limits on the liability system should be opposed or, where already enacted, repealed. The system should be allowed to work.

B. Elimination of Physician Self-Dealing. Taken alone, this will have an immediate and major impact on containing health care costs. As discussed in this paper, the medical establishment has opposed elimination or regulation of physician self-referral and, therefore, it generally has fallen on the individual states to try to limit or prohibit this costly practice.

C. Streamlining the Medical Liability System. At present, medical defendants obtain a decided advantage by delaying case resolution. Two changes at the state level would expedite case resolution:

1. Apply prejudgment interest in all medical liability cases. This would provide an incentive for liability insurers to seek early resolution as opposed to dragging cases out.

2. Develop a simplified system for handling small cases at the state level. Many cases currently are not filed because, given the medical and insurance industries' resources, litigation is simply too expensive. A simplified system for small cases would fill that void. It should, at a minimum, have strict time limits to ensure speedy resolution of claims, and simplified rules of proof and processes such as limits on experts and bans on costly discovery.

D. Reforming Malpractice Insurance. Necessary insurance reforms include compressed rate classifications and mandated experience ratings. Insurers also should not be allowed to either "skim" the risk or overreserve.

IX. Conclusion

Medical liability is a subject that has been driven largely by anecdotes and a public relations campaign supported by enormous budgets. It is too important to the quality of health care and the access to justice for millions of Americans to allow fiction to go unchallenged by fact.

We hope this paper helps separate fact from fiction and, ultimately, that the public and policymakers will realize that medical liability is not a factor in rising health care costs. Medical liability contributes to the overall quality of health care of our nation. Further, we hope that the health care debate will instigate reform -- not regressive measures of self-protection, but true reform that will secure equal justice for all.

ATLA
February 1994

Alaska State Legislature

House of Representatives

COMMITTEE ON HEALTH, EDUCATION AND SOCIAL SERVICES

DATE: 3/10/94

PLACE: Capitol Room 106

SUBJECT OF MEETING:
* HB 492: CIVIL LIABILITY; MEDICAL MALPRACTICE
* HB 493: MEDICAL LIABILITY INSURANCE LIABILITY

* INDICATES FIRST PUBLIC HEARING

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
ART SNOWDEN	COURTS					(Y)	N	HB 492
DAN HENSLEY	TRIAL LAWYERS					(Y)	N	492, 493
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

HB
493

Missing

HB

506

HOUSE COMMITTEE REPORT

(9)

Date Referred: February 16, 1994 FURTHER REFERRALS: Labor & Commerce
Finance

Date of Committee Action: 3/8/94

The HEALTH, EDUCATION AND SOCIAL SERVICES Committee considered: HB 506

HOUSE BILL NO. 506 STUDENT LOAN PROGRAM

"An Act relating to student loans; to sanctions for defaulting on a student loan, including denial of a state occupational license or disbursement of state money; and providing for an effective date."

RECOMMENDATIONS: [X] the same title
be replaced with ____ CS HB 506 HESS [ ] a new title

[ ] have attached amendments(s)

[ ] do pass

[ ] do not pass

[X] no recommendations

[ ] individual recommendations

[ ] additional referral to the _____ Committee

ADOPTS: _____ letter of Intent

ATTACHES NEW FISCAL NOTE(s): (Dept)

[X] fiscal impact CED

[X] zero fiscal note Postsecondary

APPROVES PREVIOUS: (Dept/Date)

[ ] fiscal note(s) _____

[ ] zero fiscal note(s) _____

SIGNING DO PASS	DP	OTHER RECOMMENDATIONS	DNP	NR	AM
				X	
	✓			✓	
	✓				X
	✓			X	
					X
				✓	

CHAIRMAN'S SIGNATURE

FISCAL NOTE

STATE OF ALASKA
1994 LEGISLATIVE SESSION

BILL NO. HB 506

Revision Date:
Title: An Act relating to student loans;to sanctions for defaulting on a student loan, including denial of a state . . . .
Sponsor:
Requestor:

Dept Affected: Alaska Commission on Postsecondary Education
BRU: Alaska Student Loan Corporation.
Component: Student Loan Program

COMPONENT SERIAL NO. 218

Expenditures/Revenues

OPERATING EXPENDITURES	FY95	FY96	FY97	FY98	FY99	FY00
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES	0.0	0.0	0.0	0.0	0.0	0.0
CHANGES IN REVENUES (0.0)	0.0	0.0	0.0	0.0	0.0	0.0
FUND SOURCE						
1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY94) costs ($): 0.0

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

ANALYSIS (Attach a separate page if necessary): Fiscal analysis of this bill is presented by bill section:
Section 1: this section directs Alaska Department of Commerce and Economic Development to withhold renewal of professional licenses upon notice from ACPE that a person has defaulted on an Alaskan Student Loan. Estimated cost to the ACPE to provide such notice:

FY95	FY96	FY97	FY98	FY99	FY00
0.0	0.0	0.0	0.0	0.0	0.0

(continued on reverse)

Prepared by: *Douglas S. Hanon* Phone Number: *(907) 465-6757*
Division: *Alaska Commission on Postsecondary Education* Date: 2/16/94

Approved by Commissioner *Joe L. McCormick, Executive Director* Date: 2/16/94
Agency: *Alaska Commission on Postsecondary Education*

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AK COMMISSION ON POSTSECONDARY EDUCATION - ZERO FISCAL NOTE

HB 506 Analysis (continued):

Section 2: this section creates a variable interest rate that is tied to the cost of money.

NO Fiscal Impact. Zero (0) fiscal note.

Section 3: this section amends the provisions defining the actions of the Commission if a loan is in default.

NO Fiscal Impact. Zero (0) fiscal note.

Section 4: this section provides for loan consolidation.

NO Fiscal Impact. Zero (0) fiscal note.

Section 5: this section changes eligibility for ASL if applicant has had a previous loan discharged through bankruptcy proceedings.

NO Fiscal Impact. Zero (0) fiscal note.

Section 6: this section provides for assignment of wages on a defaulted loan.

NO Fiscal Impact. Zero (0) fiscal note.

Section 7 and **Section 8**: these sections amend the requirements for family education loans.

NO Fiscal Impact. Zero (0) fiscal note.

Section 9 and **Section 10**: these sections direct the Department of Adminstration to withhold payments on person who have a defaulted Alaska Student Loan. See Section 1.

NO Fiscal Impact. Zero (0) fiscal note.

These changes to the loan servicing will create significant opportunities for operational efficiencies and, more importantly, enhance the collection efforts of the program and increase the flow of student loan receipts. The following estimate of increased receipts as a result of these changes is based upon the following assumptions: 1) collection on defaulted loans increases 6 percent per year as a result of the assignment of wages, administrations withholding of payments, and Commerce's withhold renewal of professional licenses; 2) loan consolidation will reduce the number of loans going into default by 15 percent; and 3) loan consolidation will improve collection (accounts not going into default) by 2 percent per year.

Estimated increased revenues to the Corporation:

	in thousands					
	FY95	FY96	FY97	FY98	FY99	FY00
1) Increased collection vendor	250.0	259.1	282.8	308.8	337.2	368.1
2) loan consolidation	1,200.0	1,236.0	1,298.5	1,364.2	1,433.3	1,505.8
Total	1,450.0	1,495.1	1,581.3	1,673.0	1,770.5	1,873.9

FISCAL NOTE

STATE OF ALASKA **BILL NO.** HB 506

1994 LEGISLATIVE SESSION

Revision Date: 3/3/94 Department: Commerce and Economic Dev.

Title: An Act relating to student loans;....including denial of a state occupational license..... BRU: Occupational Licensing

Component: Operations

Sponsor: House HES

Requestor: House HES COMPONENT SERIAL NO. 1844

Expenditures/Revenues (Thousands of Dollars)

OPERATING EXPENDITURES	FY 95	FY 96	FY 97	FY 98	FY 99	FY 00
PERSONAL SERVICES	42.7	42.7	42.7	42.7	42.7	42.7
TRAVEL	0.0	0.0	0.0	0.0	0.0	0.0
CONTRACTUAL	48.0	48.0	48.0	48.0	48.0	48.0
SUPPLIES	1.0	1.0	1.0	1.0	1.0	1.0
EQUIPMENT	8.0					
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	99.7	91.7	91.7	91.7	91.7	91.7
CAPITAL EXPENDITURES						
CHANGE IN REVENUES	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 General Fund						
1005 GF/Program Receipts						
1006 GF/MHTIA						
Other (Inter-Agency Receipts)	99.7	91.7	91.7	91.7	91.7	91.7
TOTAL	99.7	91.7	91.7	91.7	91.7	91.7

Estimate of any current year (FY 94) cost: $ None

POSITIONS

FULL-TIME	1.0	1.0	1.0	1.0	1.0	1.0
PART-TIME	0.0	0.0	0.0	0.0	0.0	0.0
TEMPORARY	0.0	0.0	0.0	0.0	0.0	0.0

ANALYSIS: (Attach a separate page if necessary)

HB 506 amends AS 08.02 by adding a provision that would prohibit the renewal of an occupational or business license if the licensee has failed to comply with repayment provisions of the student loan program by the Alaska Commission on Postsecondary Education. Based on approximately 180 occupational licenses and 500 business licenses which may fall within the default category, the division anticipates approximately 90 cases may result in hearings for refusal to issue a renewed license based on this amendment. (Continued on attached page)

Prepared by: Jennifer Strickler, Administrative Officer Phone: 465-2144

Division: Occupational Licensing Date: 3/3/94

Approved by Commissioner: Paul Fuhs Date: 3/3/94

Agency: Commerce and Economic Development

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CONTINUATION of FISCAL NOTE ANALYSIS
FOR BILL/RESOLUTION NO. HB 506

Under the provisions of HB 506, the division anticipates receiving a list from the Alaska Commission on Postsecondary Education that will identify individuals within their respective license program who are in default of student loan repayment provisions. Based on this list, the division is required not to renew the license of the individual until notice is received from the Alaska Commission on Postsecondary Education that the individual is no longer in default.

Based on information received from the Alaska Commission on Postsecondary Education, there were approximately 1,800 occupational licenses which matched their lists of student loan recipients, of which approximately 10% (180 licensees) were possibly in default. In addition, there are 66,000 current business licenses of which approximately two-thirds are held by sole proprietors, and possibly 500 of those licensees could be in default of the student loan repayment provisions. Of these statistics, the division anticipates that at least 90 cases will result in hearing over refusal by the division to renew a license. These hearings will undoubtedly result in time and cost to the division. To effectively administer the division's responsibilities under HB 506, the division will require funding for costs identified in this fiscal note.

PERSONAL SERVICES

1 -	Paralegal I position, Range 13, PFT, located in Juneau	$42.7

This position is anticipated to prepare the division's case against the licensee who has requested a hearing. This position will coordinate with the State's AG's, work with the hearing examiners to schedule the hearing, take the hearing examiners findings to the licensing board if applicable, monitor licensees to ensure practitioners do not continue to practice after a license has been refused renewal, and respond to public inquiries regarding the case. This position will serve as liaison between this division and the Alaska Commission on Postsecondary Education to administer and seek compliance of HB 506.

CONTRACTUAL SERVICES

Hearing Costs	$45.0

Approximately 90 cases are anticipated to result in hearings at a minimum cost of $500.00 per case. Depending on the complexity of the case, the estimated cost of $500.00 per case may be extremely low.

CONTINUATION of FISCAL NOTE ANALYSIS
FOR BILL/RESOLUTION NO. HB 506

CONTRACTUAL SERVICES, continued

Other Contractual Costs	3.0

Computer configuration management (to compare database lists), communication costs, advertising hearings and licensing actions, etc.

COMMODITIES

Daily operating supplies	1.0

EQUIPMENT (one-time costs)	8.0

This funding will provide one-time equipment and office set-up costs for the one position.

TOTAL:	**99.7**

FUND SOURCE: The division anticipates funding to be provided via RSA (inter-agency receipts) from the Alaska Commission on Postsecondary Education. Unlike the general fund program receipts funding from licensing fees, the requirement in this bill does not relate to regulation "of the profession", and therefore, would not be acceptable to increase licensing fees to fund activities under HB 506.

The division anticipates RSA funding for this program to be adjusted to actual on a yearly basis after the first year of operation.

If the business licensing program is to be excluded from the requirements of HB 506, the number of anticipated cases to result in hearings would be reduced. In addition, the need for a full-time position would also be reduced, possibly to a half-time position.

Alaska State Legislature

House of Representatives

COMMITTEE ON HEALTH, EDUCATION AND SOCIAL SERVICES

DATE: 3/8/94

PLACE: Capitol Room 106

SUBJECT OF MEETING:
* HB466: AHFC BONDS FOR UNIV OF AK USES
* HB 234: UNIV. OF AK ENDOWMENT TRUST FUNDS
- BILLS HELD OVER -
HB506: STUDENT LOAN PROGRAM
*INDICATES FIRST PUBLIC HEARING

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
Larona Derr	Doreen					(Y)	N	234
Brian Rogers	UA	207D Butrovich UA Fairbanks AK	99775		474-7448	(Y)	N	HB466 HB234
Chip Wagoner	UAF Alumi	3294 Pioneer Ave Juneau Ak	99801		586-1867	(Y)	N	H.B. 466
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

Alaska State Legislature

House of Representatives

COMMITTEE ON HEALTH, EDUCATION AND SOCIAL SERVICES

DATE:

PLACE: Capitol Room 106

SUBJECT OF MEETING:

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
Nick Abramczyk	UAF					(Y)	N	HB 466
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

H/HESS ROLL CALL FORM

BILL HB 1460 DATE 3/8/94

TAPE 94-410 NUMBER 043

SUBJECT OF VOTE TO MOVE HB 1460 OUT OF COMMITTEE

MEMBER	YEA	NAY	ABS
Rep. Cynthia Toohey	✓		
Rep. Con Bunde	✓		
Rep. Gary Davis	✓		
Rep. Al Vezey		✓	
Rep. Pete Kott			
Rep. Harley Olberg	✓		
Rep. Bettye Davis	✓		
Rep. Irene Nicholia	✓		
Rep. Tom Brice	✓		
TOTAL	7	1	

++

BILL HB 734 DATE 3/8/94

TAPE 94-410 B NUMBER 1662

SUBJECT OF VOTE TO PASS HB 734 OUT OF COMMITTEE WITH INDIVIDUAL RECOMMENDATIONS

MEMBER	YEA	NAY	ABS
Rep. Con Bunde	✓		
Rep. Gary Davis	✓		
Rep. Al Vezey		✓	
Rep. Pete Kott			
Rep. Harley Olberg			
Rep. Bettye Davis			
Rep. Irene Nicholia	✓		
Rep. Tom Brice	✓		
Rep. Cynthia Toohey	✓		
TOTAL	5	1	

Alaska State Legislature

House of Representatives

COMMITTEE ON HEALTH, EDUCATION AND SOCIAL SERVICES

DATE: 3/7/94

PLACE: Capitol Room 106

SUBJECT OF MEETING:
* HB478: EMT² Authority to Pronounce Death
* HB354: POST PONED
HB546: STUDENT LOAN PROGRAM
* INDICATES FIRST PUBLIC HEARING

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
MARK JOHNSON	DHSS, EMS	P.O. BOX 110616 JUNEAU	99811-0616	463-5807	465 3027	(Y)	N	HB 478
PAIGE ADAMS	Coalition of Student Leaders	6-B Lifesaver Drive Sitka	99835	966-2244	747-7734	(Y)	N	HB 502
DON WAINIE	DEPT OF ADMIN DIV. OF FINANCE	BOX 110204 JUNEAU, AK	99811	586-3663	465-3435	(Y)	N	HB 506
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

H/HESS ROLL CALL FORM

BILL HB 478 DATE 3/7/94

TAPE 94-38B NUMBER 783

SUBJECT OF VOTE TO PASS HB ~~HSB~~ 478 AS AMENDED OUT OF COMMITTEE WITH ACCOMPANYING FISCAL NOTE

MEMBER	YEA	NAY	ABS
Rep. Cynthia Toohey	✓		
Rep. Con Bunde	✓		
Rep. Gary Davis	✓		
Rep. Al Vezey	✓		
Rep. Pete Kott	✓		
Rep. Harley Olberg			
Rep. Bettye Davis	✓		
Rep. Irene Nicholia	✓		
Rep. Tom Brice	✓		
TOTAL	8	0	

++

BILL HB 510 DATE 3/7/94

TAPE 94-38B NUMBER 599

SUBJECT OF VOTE AMENDMENT #1, TO ADOPT

MEMBER	YEA	NAY	ABS
Rep. Con Bunde		✓	
Rep. Gary Davis		✓	
Rep. Al Vezey		✓	
Rep. Pete Kott		✓	
Rep. Harley Olberg			
Rep. Bettye Davis	✓		
Rep. Irene Nicholia	✓		
Rep. Tom Brice	✓		
Rep. Cynthia Toohey		✓	
TOTAL	3	5	

ATTACHMENT #1

Comments on HB506
Prepared by
Department of Administration - Division of Finance
March 7, 1994

Three sections of the bill affect the Division of Finance; Section 6 which relates to assignment of wages and Sections 9 and 10 which relate to withholding of disbursements made by the Department of Administration.

Section 6:
We would want to point out the potential for problems associated with student loan repayment taking priority over garnishments already in effect for an individual. Employers typically have a priority scheme for processing multiple garnishments and levies with child support taking top priority in all cases. While we cannot speak for all employers, the state's practice is to process garnishments and levies in the order in which received. Subsection (c) would alter that process by requiring the state to cease withholding for garnishments already in place and instead begin withholding for student loan repayment. Garnishments in place are normally banking institutions or other third parties with a judgement against an employee.

Sections 9 & 10:
We believe there are three possible approaches to implementing the intent of these sections, each with a different impact.

1. As written, the bill charges the Department of Administration with responsibility for performing the computer file matches and subsequent research to make absolutely certain payments are withheld from the right person.

2. Language could be included in Title 14 that has the same effect as the current language but place responsibility for research and identification of the right person on Post Secondary Education. They would then notify the Department of Administration of specific individuals for whom payments are to be withheld.

3. Under language already in Title 9, Post Secondary Education could get a court order to direct withholding of payments to a vendor.

Option 2 or 3 are the preferred option from the Department of Administration perspective. They do not create new work for which a fiscal note would be required. Option 1 creates new work in the department and would require a fiscal note.

TCN: 40443 DATE & TIME: 03/07/94 15:00 TO 16:00 STATUS:7 STATS. IN

**** ORDER SUMMARY ****
SPONSOR: HMES HOUSE HEALTH, EDUCATION AND SOCIAL SERVI CHAIRS: TOOHEY
PURPOSE: PUB PUBLIC HEARING LEGISLATIVE BUNDE
CONTACT: LYNNE SMITH TEL#: (907)465-6825
CHAIRING SITE: JUNEAU CAPITOL CAP106

SPONSOR REMARKS(PUB): TESTIMONY:Y ALLOWED 3 MINUTE LIMIT
TESTIMONY WILL BE TAKEN WITH A 3 MINUTE LIMIT
TCN REQUESTED ON 03/07/94 AND HAS 6 UPDATES

**** AGENDA ****
1 HB 478 EMT'S AUTHORITY TO PRONOUNCE DEATH

**** PARTICIPATING LIOS ****

	ANC	ANCHORAGE	716 W 4TH, #200		LOCATION STAFF
	BAR	BARROW	COURTHOUSE #305		LOCATION STAFF
	BET	BETHEL	301 WILLOW ST.		LOCATION STAFF
	COR	CORDOVA	705 2ND STREET		LOCATION STAFF
	DJT	DELTA JCT.	JARVIS CTR. #210		LOCATION STAFF
	FBX	FAIRBANKS	119 N CUSHMAN ST		LOCATION STAFF
	GLN	GLENNALLEN	COMMUNITY LIB.		LOCATION STAFF
*	JNU	JUNEAU	CAPITOL	CAP106	LOCATION STAFF
	KTN	KETCHIKAN	352 FRONT STREET		LOCATION STAFF
	SOL	KEN/SOL	34824 KALIFONSKY		LOCATION STAFF

**** VOLUNTEER & OFFNET SITES ****

ZZZ OF1 OFFNET 1	MCGRATH	BRENT URSEL	(907)524-3299
ZZZ OF2 OFFNET 2	FT. YUKON	GIG GILMORE	(907)662-2462
ZZZ OF3 OFFNET 3	GALENA	JANET NORTH	(907)656-1381

PARTICIPANTS IN:ANCHORAGE ANC

1	RONNI	SULLIVAN	S. REGION EMS		TSFY. HB 478	
	6130 TUTTLE PLACE		ANCHORAGE	AK	99507	(907)562-6449

PARTICIPANTS IN:BARROW BAR

1 MR.	DAVID	POTASHNICK	NORTHSLOPEFIRE D		TSFY. HB 478	
	PO BOX 69		BARROW	AK	99723	(907)852-0307

PARTICIPANTS IN:BETHEL BET

1	GEORGE	YOUNG	CITY OF BETHEL		OBSV. HB 478	
	PO BOX 388		BETHEL	AK	99559	(907)543-2431

23	TO	OBSERVE			OBSV. ALL ITEMS
24	TO	OBSERVE			OBSV. ALL ITEMS
25 MR.	PETE	KOTT			TSFY. HB 478
				AK	(907)000-0000

PARTICIPANTS IN:KETCHIKAN KTN

1 MR.	BILL	KRIEGSMAN	KTN. FIRE DEPT.		TSFY. HB 478	
	319 MAIN STREET		KETCHIKAN	AK	99901	(907)225-9616

PARTICIPANTS IN:KEN/SOL SOL

1 MR.	STEVE	O'CONNOR	CEN EMRGY SERV		TSFY. HB 478	
	231 S. BINKLEY ST		SOLDOTNA	AK	99669	(907)262-4792
2 CHIEF	JASON	ELSON	KEN FIRE DEPT		TSFY. HB 478	

TCN: 40443 DATE & TIME: 03/07/94 15:00 TO 16:00 STATUS:7 STATS. IN

PARTICIPANTS IN:KEN/SOL SOL

	105 S. WILLOW		KENAI	AK	99611	(907)283-7666
3 MR.	E. GENE	MERRILL	SOL HIGH SCHOOL		OBSV. HB 478	
	PO BOX 2023		SOLDOTNA	AK	99669	(907)262-8321
4 MR.	JOSH	BEVEZIN	SOL HIGH SCHOOL		OBSV. HB 478	
	PO BOX 2014		SOLDOTNA	AK	99669	(907)262-6293
5 MS.	JENNIFER	WAGNER	SOL HIGH SCHOOL		OBSV. HB 478	
	PO BOX 1356		SOLDOTNA	AK	99669	(907)262-2563
6 MS.	JOSLYN	TINKER	SOL HIGH SCHOOL		OBSV. HB 478	
	373 KATMAI		SOLDOTNA	AK	99669	(907)262-5941
7 MS.	LISA	PARKER	SOL HIGH SCHOOL		OBSV. HB 478	
	HC1 BOX 1418		SOLDOTNA	AK	99669	(907)262-7677
8 MS.	SARAH	COOPER	SOL HIGH SCHOOL		OBSV. HB 478	
	161 TRUMPTER AVE		SOLDOTNA	AK	99669	(907)262-3151

PARTICIPANTS IN:OFFNET 1 ZZZ OF1

1 MR	BRENT	URSEL			TSFY. HB 478	
			MCGRATH	AK		(907)524-3299

PARTICIPANTS IN:OFFNET 2 ZZZ OF2

1 MR	GIG	GILMORE			TSFY. HB 478	
			FT. YUKON	AK		(907)662-2462

PARTICIPANTS IN:OFFNET 3 ZZZ OF3

1 MS	JANET	NORTH			TSFY. HB 478	
			GALENA	AK		(907)656-1381
2	TO	TESTIFY			TSFY. ALL ITEMS	

PO BOX 388 BETHEL AK 99559 (907)543-2151

PARTICIPANTS IN:DELTA JCT. DJT

1	MS.	ELLEN	WOFFORD	DELTA RESCUE SOD OBSV. HB 478		
		PO BOX 1357		DELTA JUNCTION	AK	99737 (907)895-4746
2	MR.	JOEY	PEYTON	DELTA RESCUE SOD TSFY. HB 478		
		PO BOX 585		DELTA JUNCTION	AK	99737 (907)895-4975
3	MR.	DONALD	FRANK	DELTA RESCUE OBSV. HB 478		
		HC 60 BOX 4430		DELTA JUNCTION	AK	99737 (907)895-5109

PARTICIPANTS IN:FAIRBANKS FBX

1	MR.	THOMAS	SWAN	TSFY. HB 478		
		PO BOX 83226		FAIRBANKS	AK	99708 (907)488-3327
2	MR.	CRAIG	LEWIS	TSFY. HB 478		

LTN1100-R01 LEGISLATIVE TELECONFERENCE NETWORK PAGE 02
03/14/94 11:22:34
TCN: 40443 DATE & TIME: 03/07/94 15:00 TO 16:00 STATUS:7 STATS. IN

PARTICIPANTS IN:FAIRBANKS FBX

		1112 LAKE DR.		NORTH POLE	AK	99705 (907)456-3978
3	MR.	THOMAS	NAROW	AK		TSFY. HB 478
		P.O. BOX 10929		FAIRBANKS	AK	99710 (907)488-4221

PARTICIPANTS IN:GLENNALLEN GLN

1	Ms.	ELIZABETH	MUIR DELANEY	C.R.E.M.S.		OBSV. HB 478
		PO BOX 529		GLENNALLEN	AK	99588 (907)822-3671

PARTICIPANTS IN:JUNEAU JNU

1	REP	CYNTHIA	TOOHEY		TSFY. HB 478
				AK	(907)000-0000
2	REP	CONDE	BUNDE		TSFY. HB 478
				AK	(907)000-0000
3	REP	AL	VEZEY		TSFY. HB 478
				AK	(907)000-0000
4	REP	GARY	DAVIS		TSFY. HB 478
				AK	(907)000-0000
5	REP	HARLEY	OLBERG		TSFY. HB 478
				AK	(907)000-0000
6	REP	TOM	BRICE		TSFY. HB 478
				AK	(907)000-0000
7	REP	BETTYE	DAVIS		TSFY. HB 478
				AK	(907)000-0000
8	REP	IRENE	NICHOLIA		TSFY. HB 478
				AK	(907)000-0000
9	REP	GENE	THERRIAULT		TSFY. HB 478
				AK	(907)000-0000
10		TO	OBSERVE		OBSV. ALL ITEMS
11		TO	OBSERVE		OBSV. ALL ITEMS
12		TO	OBSERVE		OBSV. ALL ITEMS
13		TO	OBSERVE		OBSV. ALL ITEMS
14		TO	OBSERVE		OBSV. ALL ITEMS
15		TO	OBSERVE		OBSV. ALL ITEMS
16		TO	OBSERVE		OBSV. ALL ITEMS
17		TO	OBSERVE		OBSV. ALL ITEMS
18		TO	OBSERVE		OBSV. ALL ITEMS
19		TO	OBSERVE		OBSV. ALL ITEMS
20		TO	OBSERVE		OBSV. ALL ITEMS
21		TO	OBSERVE		OBSV. ALL ITEMS
22		TO	OBSERVE		OBSV. ALL ITEMS

Comments on HB506
Prepared by
Department of Administration - Division of Finance
March 7, 1994

Three sections of the bill affect the Division of Finance; Section 6 which relates to assignment of wages and Sections 9 and 10 which relate to withholding of disbursements made by the Department of Administration.

Section 6:
We would want to point out the potential for problems associated with student loan repayment taking priority over garnishments already in effect for an individual. Employers typically have a priority scheme for processing multiple garnishments and levies with child support taking top priority in all cases. While we cannot speak for all employers, the state's practice is to process garnishments and levies in the order in which received. Subsection (c) would alter that process by requiring the state to cease withholding for garnishments already in place and instead begin withholding for student loan repayment. Garnishments in place are normally banking institutions or other third parties with a judgement against an employee.

Sections 9 & 10:
We believe there are three possible approaches to implementing the intent of these sections, each with a different impact.

1. As written, the bill charges the Department of Administration with responsibility for performing the computer file matches and subsequent research to make absolutely certain payments are withheld from the right person.

2. Language could be included in Title 14 that has the same effect as the current language but place responsibility for research and identification of the right person on Post Secondary Education. They would then notify the Department of Administration of specific individuals for whom payments are to be withheld.

3. Under language already in Title 9, Post Secondary Education could get a court order to direct withholding of payments to a vendor.

Option 2 or 3 are the preferred option from the Department of Administration perspective. They do not create new work for which a fiscal note would be required. Option 1 creates new work in the department and would require a fiscal note.

March 7, 1994

Alaska House of Representatives
Health, Education and Social Services Committee

Co-Chairs Reps. Con Bunde and Cynthia Toohey:

I would like to submit written testimony pertinent to your consideration today of HB 506, Student Loan Reforms. I am testifying on my own behalf and on behalf of the Alaska State Chamber of Commerce, which stands in support of the proposed reforms after adopting a resolution to that effect at its October board meeting in Anchorage.

The provisions of HB 506 contain much-needed measures to help lower the default rate and to insure that borrowers in the program act responsibly as they progress into their careers after graduation.

Equally as importantly, the bill would set a floating rate, tied to the cost of funds and administration of the program, making future legislative revisions unnecessary as the bonds that provide money to lend vary in cost.

Having attended sessions of the statewide student group as a guest, while they considered this matter, I was impressed with the resolve of the students to support the anti-default measures. They recognized that, while it might be some of their heads on the block one day, the concept was an important one for the viability of the program and the sale of bonds in the private market.

Aside from general support of this bill, the one point I want to make is that continuation of a healthy Alaska Student Loan Program is an important public policy move for the state, to encourage retention of our youth as workers and business owners in a health Alaskan economy. The dollars lent in this program return, in large part, to Alaska as tuition and fees in both the UA system and at the private colleges in our state. It's a very positive way to inject outside dollars into the state's economy.

Thank you for taking the time to consider my testimony.

Steve Levinson, Managing Director/USA
Alaska European Sales Co.
Box 930
Dillingham, Ak 99576

by Vezey

Amendment to HB 506

Page 5 Line 19. After court add " or until the employment of the obligee is terminated."

STATE OF ALASKA

ALASKA COMMISSION ON POSTSECONDARY EDUCATION

WALTER J. HICKEL, GOVERNOR

BOX 110505
JUNEAU, ALASKA 99811-0505
PHONE (907) 465-2962
FAX (907) 586-4002

SUGGESTED AMENDMENTS TO HB506

Restrict the impact of Section 1 to persons licensed for professional and/or occupational licenses only.

Provide the Department of Commerce and Economic Development with the authority to require that applicants for professional/occupational licenses disclose their Social Security Numbers to provide for tracking and eligibility determination information.

Amend Section 4, dealing with loan refinancing, so that the weighted average of the interest rates be rounded to the nearest tenth of a percent.

Amend Section 9, dealing with the withholding of State warrants, so that only disbursement of payments for good and services provided by an individual contractor would be withheld.

RE: Potential amendment to cap variable interest rate. If the committee seeks to amend the bill to include an eight percent cap, that the cap be placed on the **true interest rate and not the rate as subsidized by the state through interest deferment.**

RE: Questions regarding appeal/hearing process. Commission statutes already provide for an appeal process and Commission has in place a hearing process that is used for borrowers who protest the garnishment of their Alaska Permanent Fund Dividend.

8-LS1752\A.2
Ford
3/4/94

AMENDMENT

OFFERED IN THE HOUSE BY REPRESENTATIVE BRICE

TO: HB 506

Page 2, lines 6 - 14:

Delete all material and insert:

"(f) Except as provided in this section, interest on a loan made under AS 14.43.090 - 14.43.160 is equal to the interest rate (1) paid in each year on bonds issued by the Alaska Student Loan Corporation under AS 14.42.220; and (2) necessary to pay a percentage of the administrative cost of the student loan program that is represented by the loan; in determining a rate of interest under this paragraph, the commission shall use a method that ensures that the rate of interest is as low as possible without precluding the ability of the commission to administer loans made under AS 14.43.090 - 14.43.160. Interest on a loan described in this subsection may not exceed 15 percent a year."

Alaska State Legislature

House of Representatives

COMMITTEE ON HEALTH, EDUCATION AND SOCIAL SERVICES

DATE: 3/3/94

PLACE: Capitol Room 106

SUBJECT OF MEETING:
* HB 506: STUDENT LOAN PROGRAM
* HB 356: LIVING WILLS AND MEDICAL CARE ORDERS
BILLS HELD OVER FROM PREVIOUS CALENDARS
* HB 333: DRUG FREE RECREATION AND YOUTH CENTERS
* HJR 52: INCREASE IN FEDERAL MEDICAID FUNDED

NAME	REPRESENTING	BUSINESS/PERSONAL MAILING ADDRESS	ZIP	(H) PHONE	(W) PHONE	DO YOU WANT TO TESTIFY?		WHAT SUBJECT/ WHICH BILL?
MARK JOHNSON	ANSS, EMS	P.O.BOX 110616 Juneau	99811-0616	463-5807	465-3027	(Y)	N	HB 356
Vona Hall	AHR Pasel	2590 Glacier Highway	99801	780-4089	780-4089	(Y)	N	HB 356
Rupe Andrews	AARP	9416 Long Run, Juneau	99801		789-7422	Y	(N)	HB 356
Kim Bunch	DHSS				465-3391	(Y)	N	HJR 52
~~Stevie Hon~~						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	
						Y	N	

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LTM1100-R01              LEGISLATIVE TELECONFERENCE NETWORK                  PAGE  01
03 11/94                                                                     11:45:58
    TCN: 40411     DATE & TIME: 03/03/94 15:00 TO 17:00  STATUS:7  STATS. IN

**** ORDER SUMMARY ****
SPONSOR: HHES HOUSE HEALTH, EDUCATION AND SOCIAL SERVI CHAIRS: TOOHEY
PURPOSE: PUB  PUBLIC HEARING          LEGISLATIVE                  BUNDE
CONTACT:      LYNNE SMITH      TEL#: (907)465-6825
CHAIRING SITE: JUNEAU          CAPITOL          CAP106

SPONSOR REMARKS(PUB): TESTIMONY:Y ALLOWED          5 MINUTE LIMIT
HB 356 WILL NOT BE THE FIRST BILL ON THE CALENDAR.
TESTIMONY WILL BE TAKEN WITH A 5 MINUTE LIMIT.
TCN REQUESTED ON 03/03/94 AND HAS  7 UPDATES

**** AGENDA ****
    1  HB 356 LIVING WILLS AND MEDICAL CARE ORDERS
    2  HB 506 STUDENT LOAN PROGRAM

**** PARTICIPATING LIOS ****
    COR CORDOVA            705 2ND STREET                    LOCATION STAFF
    FBX FAIRBANKS          119 N CUSHMAN ST                  LOCATION STAFF
    HOM HOMER LTC          126 W PIONEER #4                  LOCATION STAFF
 *  JNU JUNEAU             CAPITOL              CAP106       LOCATION STAFF
    MAT MATSU              165 E PARKS HWY.                  LOCATION STAFF
    PSG PETERSBURG         101 GJOA STREET                   LOCATION STAFF
    SEW SEWARD             2091 SEWARD HWY                   LOCATION STAFF
    SIT SITKA              210 LAKE STREET                   LOCATION STAFF
    SOL KLN/SOL            34824 KALIFONSKY                  LOCATION STAFF

**** VOLUNTEER & OFFNET SITES ****
  ZIZ OF1 OFFNET 1         FAIRBANKS            CRAIG LEWIS      (907)456-3978

PARTICIPANTS IN:FAIRBANKS          FBX
  1 MR.    BRIAN          BRUBAKER          COAL.STUD.LEADER TSFY. HB 506
           PO BOX 84791                FAIRBANKS          AK 99708 (907)474-9052
  2 MR.    NICHOLAS       ABRAMCZYK           ASUAF            TSFY. HB 506
           PO BOX 99775                FAIRBANKS          AK 99775 (907)474-5156

PARTICIPANTS IN:HOMER LTC          HOM
  1 MRS.   MILDRED        MARTIN                                OBSV. HB 356
           PO BOX 2652                 HOMER              AK 99603 (907)235-6652
  2 MS.    BRENDA         STEENBLOCK        SENIOR CITIZENS  OBSV. HB 356
           3935 SVEDLUND ST            HOMER              AK 99603 (907)235-7675

PARTICIPANTS IN:JUNEAU             JNU
  1        TO             OBSERVE                               OBSV. ALL ITEMS
  2        TO             OBSERVE                               OBSV. ALL ITEMS
  3        TO             OBSERVE                               OBSV. ALL ITEMS
  4        TO             OBSERVE                               OBSV. ALL ITEMS
  5        TO             OBSERVE                               OBSV. ALL ITEMS
  6        TO             OBSERVE                               OBSV. ALL ITEMS
  7        TO             OBSERVE                               OBSV. ALL ITEMS
  8        TO             OBSERVE                               OBSV. ALL ITEMS
  9        TO             TESTIFY                               TSFY. ALL ITEMS
 10        TO             TESTIFY                               TSFY. ALL ITEMS
 11        TO             TESTIFY                               TSFY. ALL ITEMS
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ICN: 40411 DATE & TIME: 03/03/94 15:00 TO 17:00 STATUS:Y STATS. IN

PARTICIPANTS IN:JUNEAU JNU

13	TO	TESTIFY		TSFY. ALL ITEMS
14	TO	TESTIFY		TSFY. ALL ITEMS
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26	TO	TESTIFY		TSFY. ALL ITEMS
27	TO	TESTIFY		TSFY. ALL ITEMS
28	TO	TESTIFY		TSFY. ALL ITEMS

PARTICIPANTS IN:MATSU MAT

1	MR	ERNEST	LINE			TSFY. HB 356
		2654 WHISPERING WOODS DR		WASILLA	AK	99645 (907)376-6709

PARTICIPANTS IN:PETERSBURG PSG

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2	MRS.	FLORENCE	LEROY			OBSV. HB 356
		P.O. BOX 313		PETERSBURG	AK	99833 (907)772-3200

PARTICIPANTS IN:SEWARD SEW

1	MS.	JULIE	RENWICK	WESLEY REHAB		TSFY. HB 336
		PO BOX 1066		SEWARD	AK	99664 (907)224-5241
2	MS.	BARBARA	BLACKWELL, R.N.	WESLEY REHAB		OBSV. HB 356
		PO BOX 1541		SEWARD	AK	99664 (907)224-8613
3	MS.	JOAN	CLEMENS, R.N.	WESLEY REHAB		OBSV. HB 356
		PO BOX 1345		SEWARD	AK	99664 (907)224-3674
4		MARJORIE	MCELDOWNEY R.N.	SEWARD HOSPITAL		OBSV. HB 356
		PO BOX 365		SEWARD	AK	99664 (907)224-5205
5		DOREEN	BOOTH	SEWARD HOSPITAL		OBSV. HB 356
		PO BOX 365		SEWARD	AK	99664 (907)224-5205
6		LINDA	SWENSON RN	SEWARD HOSPITAL		TSFY. HB 356
		PO BOX 365		SEWARD	AK	99664 (907)224-5205
7	MS.	ELLEN	O'BRIEN	SEWARD HOSPITAL		OBSV. HB 356
		PO BOX 365		SEWARD	AK	99664 (907)224-5205
8	MS.	DITA	DEBOER	RBHC		OBSV. HB 356
		PO BOX 1526		SEWARD	AK	99664 (907)224-3181
9	MR.	RICHARD	JONES, (DIRECTOR)	SGH RBHC WR&CC		TSFY. HB 356
		PO BOX 361		SEWARD	AK	99664 (907)224-5241
10		DOROTHY	LOCKE	SPRING CREEK CC		OBSV. HB 356
		BOX 2109		SEWARD	AK	99664 (907)224-8200
11		ANN	WHITMORE-PAINTER	WRCC		OBSV. HB 356
		PO BOX 516		MOOSE PASS	AK	99631 (907)288-3143

PARTICIPANTS IN:SITKA SIT

1		NANCY JO	KLEIER	SEARHC		TSFY. HB 356

TCP: 4041 DATE & TIME: 03/03/94 15:00 TO 17:00 STATUS:T STATS. IN

PARTICIPANTS IN:SITKA SIT

	222 TONGASS	SITKA	AK	99835	(907)966-8413
2	ANDREA PAIGE ADAMS	UAS/SITKA		TSFY. HB 506	
	6-B LIFESAVER DRIVE	SITKA	AK	99835	(907)966-9244

PARTICIPANTS IN:KEN/SOL SOL

1	MS.	LINDA	KRISTENSEN	CPC-FORGETMENOT	OBSV. HB 356	
		905 COOK AVE. STE. B	KENAI	AK	99611	(907)283-7294

PARTICIPANTS IN:OFFNET 1 ZZZ OF

1	CRAIG	LEWIS		TSFY. HB 356	
		FAIRBANKS	AK		(907)456-3478

February 20, 1994

University of Alaska

Coalition of Student Leaders

OFFICIAL POSITION

Regarding

Student Loan Reform

The Coalition of Student Leaders of the University of Alaska accepts the recommendations of the Alaska Commission on Postsecondary Education as its official position, except for the following modifications:

1. That in the first recommendation, we believe that the interest rates for student loans should never exceed eight percent; and

2. That in recommendations four and five, provisions should be included so that debtors in default can make appeals for exceptions to these proposed measures.

For further information, contact:

Scott Otterbacher, Student Regent & Coalition Spokesperson, 373-4628, Fax 373-7363:
Brian Brubaker, Coordinator, 474-5214;
or Pat Ivey, System Governance, 474-7323, Fax 474-5131

HB 506 – Amendment # 4

Section 4 (b): proposed language change

(b) Notwithstanding AS14.43.120(f), if loans are consolidated under (a) of this section, the consolidated loan shall bear annual interest equal to the weighted average of the interest on the loans being consolidated, rounded to the nearest tenth of a percent.

Rationale: Currently, the bill reads "rounded to the nearest whole percent." Rounding up could mean the student pays a higher interest rate on the consolidated loan than he/she would on the loans separately; while rounding down would mean that the state loses interest due. By allowing interest rates on consolidated loans to be set in tenths of a percent, the losses to either the state or the student are minimized.

For example, if a student wishes to consolidate loans amounting to $10,000, $7,500 of which are at 8% and $2,500 of which are at 5%, the weighted interest rate is 7.25%.

Under the existing language, the state would have to consolidate the loans at 7%, thereby losing .25% interest. Under the proposed language, the rate would be rounded to 7.3%.

8-LS1752\A.1
Ford
2/28/94

A M E N D M E N T

OFFERED IN THE HOUSE

TO: HB 506

Page 6, line 30, after "if":

Insert "the disbursement is due under terms of a written contract with that person and"

WALTER J. HICKEL, GOVERNOR

ALASKA COMMISSION ON POSTSECONDARY EDUCATION

BOX 110505
JUNEAU, ALASKA 99811-0505
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SUBJECT: AN ACT RELATING TO TERMS AND CONDITIONS OF THE ALASKA STUDENT LOAN PROGRAM

The following is a synopsis of the legislative recommendations of the Alaska Commission on Postsecondary Education as included in House Bill 506:

1) Variable Interest Rate. Recommend that AS 14.43.120 (f) be amended so that the annual rate of interest on Alaska Student Loans will be set each year by adding to the true interest rate for that year's tax exempt bonds an additional percentage designed to cover the administrative costs of the program. Included in the amendment should be language mandating that the Commission insure that the effective borrower interest rate be as low as possible without threatening their ability to properly service loans.

2) Restricted Loan Eligibility After a Write-off. Recommend that AS 14.43 be amended so that a loan applicant would be considered ineligible to receive a new Alaska Student Loan for no less than five (5) years subsequent to having any portion of a prior Alaska Student Loan discharged or written-off for any reason.

3) Wage Garnishment. Recommend that AS 14.43 be amended to include a section authorizing income withholding for borrowers in default on their Alaska Student Loan. The effect of this amendment would be that any judgment or court order regarding a defaulted borrower must contain an income withholding order.

4) Denial of State License Renewals. Recommend that AS 14.43 and AS 08.01 be amended so that borrowers in default on their Alaska Student Loans would be ineligible to renew an existing license to do business or practice an occupation in Alaska until the Department of Commerce is notified by the Commission that the applicant's loan account has been brought current.

5) Denial of State Warrants. Recommend that no State warrant shall be issued to a borrower who is in default on an Alaska Student Loan. Any and all warrants resulting from business done with the State would be withheld until the affected department is notified by the Commission that the applicant's loan account has been brought current.

6) Refinancing Alaska Student Loans. Recommend that AS 14.43. be amended so that the Commission could offer borrowers the option to collapse variable term loans into a single loan. The interest rate on the refinanced loan would be the weighted average of all loans included. A married couple may consolidate their individual loans if they agree to be held jointly and separately liable for repayment of the refinanced loan regardless of the amount of their previously individual debts, and in spite of any future change in their marital status. The loan is not dischargeable in the event that one spouse dies.

7) Expand Family Education Loan Eligibility. Recommend that AS 14.43. 750 and AS 14.43.740 be amended to remove the dependency requirement which would allow one family member to borrow on behalf of another member of their immediate family, and to clarify that it is the borrower only who must meet the Alaska residency requirement.

POSITION PAPER ON HOUSE BILL 506

Alaska Commission on Postsecondary Education
March 3, 1994

House Bill 506--an act relating to student loans and to sanctions for defaulting on a student loan--has been introduced by the House Committee on Health, Education and Social Services at the request of the Alaska Commission on Postsecondary Education (ACPE). The legislation has been crafted to address several significant problems encountered in the administration of the Alaska Student Loan program: specifically, the need to protect an eroding capital base by increasing loan repayment and by lending at rates which reflect costs of capital.

This paper provides the context within which the bill should be considered as well as the rationale for each of the sections.

BACKGROUND

The Alaska Student Loan Program (ASL) began in 1971 as a student assistance program supported by the state General Fund. The program grew out of a widely-expressed desire that the state's new oil wealth be used, in part, to increase educational opportunities for Alaska students. For the first decade and a half, the program was generously supported by general fund appropriations. However, as oil prices and state oil revenues declined, full state funding could no longer be assured and a separate state entity--the Alaska Student Loan Corporation--was established by the legislature to raise alternative financing in the form of tax-exempt bonding. Since the first bond sale in spring of 1988, the Corporation has raised more than $250 million in private capital markets to support student loans.

Over its 20 plus years of existence, the ASL program has undergone numerous legislative changes:

- loan maximums have been raised from $2,500 to $5,500 for undergraduate study;
- loan interest rates have increased from 5% to 8%;
- the loan repayment period has been extended from 6 to 10 years; and
- forgiveness benefits for those borrowers returning to the state have gone from 40% to 50% and then to zero.

By and large, program changes from 1971 to 1986 were made to benefit students by providing easier access to larger amounts of postsecondary education aid. Although the program was originally created as a revolving loan fund, provisions such as forgiveness and interest subsidies while the student remained in school assured that the fund could not continue without infusions of state support. In 1986, forgiveness benefits were ended and interest subsidies were reduced in an attempt to cut back--but not eliminate--this drain on state resources.

With the advent of private funding through tax-exempt bonds, the ASL began to shift from a student-centered program to one responsible to bondholders. Loan conditions which resulted in losses to fund principle or to earned interest--such as forgiveness provisions and in-school interest subsidies--could be continued only with state general fund appropriations to replace losses. Although such appropriations did continue through FY92, the amount of the appropriation was never related to the losses incurred by mandated loan conditions. Today, the fund receives no state support. Thus, the student loan fund continues to expense forgiveness and interest subsidy benefits with no compensating revenue source.

Bad debts are a further drain on the capital base. The program has succeeded in reducing its default rates from the high levels of the mid-1980's; however, it continues to write off a portion of its portfolio as non-performing. In addition, some loans must be canceled because of death or disability of the borrower. The following table shows the annual and cumulative effect of the forgiveness and write off provisions since the program transitioned to bond funding.

Table 1
Losses to the Alaska Student Loan Fund

Fiscal Year	Forgiveness	Loan write offs
FY88	$5,612.5	$500.0
FY89	$6,050.6	$800.0
FY90	$6,598.2	$5,001.0
FY91	$8,801.4	$6,426.3
FY92	$7,894.8	$6,753.0
FY93	$7,675.9	$8,454.8
Total	**$42,633.4**	**$27,935.1**

A further erosion of the fund occurs because the statutorily-set interest rate on loans (8% simple interest since FY87) has, until this current year, resulted in a gap between the effective rate on loans and the true cost of capital. For a typical college student who borrows for four years, the effective rate over all of the loans is 5.8% because interest is deferred while the student is in school. The following table displays the difference between the bond rates and the interest received on a four-year collegiate loan.

Table 2
Difference Between Cost of Capital
to Program and to Borrower

School Year	True Interest Rate on Bonds	Effective Interest Rate on 4-year Loan	Difference (Subsidy)
1988/89	8.4%	5.8%	-2.6%
1989/90	8.1%	5.8%	-2.3%
1990/91	7.3%	5.8%	-1.5%
1991/92	6.7%	5.8%	-0.9%
1992/93	6.0%	5.8%	-0.2%
1993/94	5.5%	5.8%	0.3%

At the present borrowing rate, effective interest just covers the cost of capital for the most recent bond sale; however, it does not allow the fund to recover any loan awarding and servicing costs. In earlier days, administrative costs were supported by general fund appropriations. Since FY88, however, these program costs have been taken from program receipts--that is, from repayments on prior loans.

A recent legislative audit of the Alaska Student Loan Program[1] recognizes the changed fiscal situation of the program and the strains that earlier legislation and state policy have placed on maintaining fund viability. The report recommends that the loan fund be secured. The proposed legislation seeks to follow that recommendation by recognizing the true cost of capital, accounting for reasonable administrative expenses and increasing penalties for non-repayment of loans.

[1] Division of Legislative Audit, *Alaska Student Loan Corporation Organizational and Operational Efficiency and Alternatives*, October 28, 1993 (Audit Control No. 05-4466-94). The findings were echoed by the Legislative Research Agency in *Privatizing the Alaska Student Loan Program*, a January 4, 1994 research report prepared at the request of Rep. Mark Hanley (Research Request 94.068)

SECTIONAL ANALYSIS

Section 1 prohibits the Department of Commerce and Economic Development from renewing an occupational or professional license if the licensee is in default on an Alaska student loan. ACPE must notify the Department of defaulting borrowers.

Rationale: Borrowers who have received state support for education or training leading to a occupational/professional license must honor their loan repayment obligations. The legislation allows the original license to be issued in order that the borrower may earn the income necessary to repay the loan. If repayment is not made in a consistent and timely manner, however, the borrower should not continue to benefit from the state's investment.

Section 2 ties the interest rate on a student loan to 1) the cost of the private capital backing that loan and 2) a portion of the administrative expense of disbursing and servicing the loan. Under the legislation, the interest rate would be set annually by the Commission, by a method that "ensures that the rate of interest is as low as possible without precluding the ability of the commission to administer loans."

Rationale: The present interest rate of 8% bears no relationship to either the interest paid on bonds or the cost of running the loan program. Today's capital market provides a very advantageous rate to tax-exempt bond issuers. Savings from low rates should benefit students. By the same token, in times of higher rates, the costs must be passed on to the borrowers if the fund is to remain sound. And, in all cases, loan interest rates must include reasonable overhead costs. The legislation explicitly charges the commission to keep these overhead costs to minimum.

Section 3 directs the Commission to notify the Departments of Administration and of Commerce and Economic Development when a borrower is in default.

Rationale: Since these two departments are charged with withholding benefits from defaulted borrowers, it is incumbent upon the Commission to provide timely notification of default status.

Section 4 allows the Commission to consolidate a borrower's or a married couple's loans. Married borrowers must agree to be jointly and severally liable for repayment and the loan is not forgiven on the death of one of the borrowers.

Rationale: The existing loan portfolio is composed of loans of varying conditions and interest rates, as shown in the following table.

Table 3
Loan Portfolio by Loan Conditions

Type of Loan	Percent of Portfolio
5% interest	27%
8% with no grace year interest	13%
8% with grace year interest	60%

Each loan is accounted for separately. Borrowers are often confused by the billing statement and by the apportionment of the monthly payment across the various loans. In some cases, a borrower may choose to pay off a higher interest loan more rapidly than a lower interest one. In order to split payment in such cases, staff must enter the payment manually. Approximately one and three-quarters FTE staff time is directed to manual posting of these payments each month. Because the loan consolidation provided in this bill is optional on the part of the borrower, not all of these arrangements will be eliminated. However, borrowers will be encouraged to take the option and a significant decrease in special payments is anticipated.

Section 5 excludes from eligibility any borrower who has had a previous loan written off by the Commission within the previous five years.

Rationale: Currently, a borrower can have a student loan written off if the borrower is certified as 50% or more disabled by two doctors or if a loan has been discharged by a bankruptcy proceeding. Nothing in present statute prohibits a borrower from applying for and obtaining a new loan immediately. The proposed language would close this loop hole.

Section 6 allows the courts to assign to the Commission a portion of a defaulter's wages.

Rationale: Wage assignment is a powerful tool for enforcing loan repayment. In many cases, the threat of withholding wages is sufficient to encourage repayment. Where an assignment has been made, the loan fund benefits from at least partial payments.

Section 7 applies the one-year residency requirement for Family Education (FEL) to the borrower rather than the student. Current statutes require both the borrower and the student to meet the requirements.

Rationale: The Commission frequently encounters situations where a separated or divorced Alaskan resident parent wishes to borrower on behalf of a child for whom he/she does not have physical custody. In these cases, the parent with custody is often not a resident. The intent of the FEL program was to encourage parents to assist in funding a child's postsecondary education. FEL borrowers are generally very credit worthy and the default rate on these loans approaches zero. Therefore, it is in the best interests of the loan program to expand participation in this program to eligible Alaskans.

Section 8 deletes the requirement that an FEL loan can be made only on the behalf of a child who has been claimed as a dependent for federal tax purposes.

Rationale: Many potential FEL participants wish to borrow for children who are no longer claimed as dependents but who still need assistance in pursuing postsecondary education goals. Additionally, some parents object to sharing federal tax information with the loan program. The proposed changes would further encourage family responsibility and would provide relatively secure assets for the loan program without violating the financial privacy of the borrower.

Sections 9 and 10 prohibit the Department of Administration from disbursing state funds to persons who are in default on a student loan.

Rationale: Persons under contract to provide goods and services or who receive other remuneration from the state should be current on their obligations to the state. Together with wage assignment and the denial of license renewal, the threat of withholding payment puts borrowers on notice that the state takes repayment of student loans very seriously.

CONCLUSION

The Commission supports HB 506 because it provides the tools for fiscally-responsible management of the Alaska Student Loan program. Without the provisions of this bill, the fund will continue to erode. With it will erode the higher education opportunities for the coming generations of Alaskan students.