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> "the ethical advances of appellate decisions that have marked the greatness of our common law under traditional tort principles."[92] Patricia Danzon says the program costs of a comprehensive no-fault system "could indeed be staggering."[93]

One commentator suggests that if physicians funded the compensation pool, they would have an incentive to practice non-negligent medicine; and that if the only compensable outcomes be those that normally occur as a result of negligence, award would imply fault.

ACCELERATED COMPENSATION EVENTS

The idea for accelerated compensation events was conceived in the 1970s. This approach would remove certain medical injuries from the tort system and on to a faster track in which they are covered by private or social insurance. Injuries would be selected as accelerated compensation events because they should not occur, and because they are relatively avoidable and easily identifiable (a classic example is the sponge left in a patient).

The Intergovernmental Health Policy Project reports that no state legislation has been introduced as yet to set in motion an accelerated compensation system (ACE), but that its proponents are "aggressively searching" for locations in which to field test their idea.[94] Analysts Laurence Tancredi (who originated the idea) and Randall Bovbjerg (the lead author in a recent study of how the plan affects obstetrics cases) say the idea is ready for the real world of state policy:[95]

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[92]Ralph Nader and Joan Claybrook, "Preserving a Pillar of Our Democracy: Tort System Protects the Injured," *Trial*, December 1991, pp. 45-49.

[93]Patricia Danzon, *Medical Malpractice: Theory, Evidence and Public Policy*, Harvard University Press, 1985, p. 216.

[94]"Medical Malpractice: An Overview of 1991 State Legislative Activity," Intergovernmental Health Policy Project, the George Washington University, Washington, D.C.

[95]The first articles on accelerated (or "designated") compensable events were published by Laurence R. Tancredi and Clark C. Havighurst in the 1970s. The articles used in this report are Laurence Tancredi and Randall Bovbjerg, "Rethinking Responsibility for Patient Injury: Accelerated-Compensation Events, a Malpractice and Quality Reform Ripe for a Test," *Law and Contemporary Problems*, Spring 1991, pp. 147-177; and Randall Bovbjerg, Laurence Tancredi and Daniel Gaylin, "Obstetrics and Malpractice: Evidence on the Performance of a Selective No-Fault System," *Journal of the American Medical Association*, Vol. 265, No. 21, June 5, 1991, pp. 2836-2843.

"The next generation of ACE work needs to convince practical people--state legislators as well as health care providers--that versions of ACEs deserve the chance to demonstrate their practicality on their own" (*Law and Contemporary Problems*, Spring 1991, page 177).

They caution that, although their approach is similar to the no-fault birth injury plans followed by Florida and Virginia, it "covers far more of the problem outcomes." They say it creates "far better" incentives for prevention of injury and, in sum, offers a "major improvement" for handling obstetrical injuries for practitioners and patients alike. The discussion that follows is taken from work by Dr. Tancredi, professor of medicine and the law at the University of Texas Health Science Center in Houston, and Mr. Bovbjerg, a lawyer and senior research associate with the Urban Institute in Washington, D.C.

Benefits of the Accelerated Compensation Events Plan

Dr. Tancredi and Mr. Bovbjerg say the accelerated compensation event approach covers more injuries on a regular basis than does the liability system; removes most serious injuries from litigation; achieves administrative savings; and is unlikely to promote large numbers of expensive new cases. Finally, "it will almost surely mean less aggravation for all concerned."

These authors say the ACE concept is flexible enough to fit varied social, economic or political requirements. They cite two examples:

- **Cost.** If cost is a problem, an ACE can be narrowly defined. A list of obstetrical ACEs might be limited to the most serious economic injuries, leaving the remainder to the tort system or another alternative. The authors say that this approach is "similar but far broader" than the Virginia and Florida "very limited" definitions of birth-related neurological injury.

- **Practicality.** If policy makers want to move slowly, ACEs can be phased in, beginning perhaps with obstetrics and gynecology and general surgery, leaving other care to the existing tort system or another alternative. This would allow for practical experience, monitoring and alterations. Other specialties could be added gradually.

The authors say that ACEs can also fit into existing tort system or insurance carrier scenarios. For example, ACEs could be used:

- outside of the fault system, eliminating questions about physician fault (leaving non-ACE injuries to the fault-based system);

- in the current fault system during pretrial review or arbitration;
- as the basis for a new kind of medical injury insurance for "insurable events"; and
- to monitor and analyze bad outcomes in efforts to improve quality of care.

Articles describing in detail several possible ACE systems include Tancredi and Bovbjerg, "Rethinking Responsibility for Patient Injury: Accelerated-Compensation Events, A Malpractice and Quality Reform Ripe for a Test," *Law and Contemporary Problems*, Spring 1991, pp. 147-177, as well as an article describing how the system would affect obstetrics cases in a large survey of cases from 24 states between 1983 and 1989: Bovbjerg, Tancredi and Gaylin, "Obstetrics and Malpractice: Evidence on the Performance of a Selective No-Fault System," *Journal of the American Medical Association*, June 5, 1991, pp. 2836-2843.

PRO: Dr. Tancredi and Mr. Bovbjerg say the ACE system is attractive because it offers widespread and fair compensation; prompt compensation; better prevention of medically caused injuries; more efficient administration; little incentive for defensive medicine; improved physician-patient relations; and greater confidence in the accuracy and fairness of the system.

CON: Critics say medical injuries cannot be distinguished from problems associated with underlying conditions; that so few injuries would be included in any practical ACE list that the current system would be virtually unchanged; that most ACEs are currently solved through informal settlement and few go to trial anyway; or that such a no-fault system would create a huge increase in cases.[96]

EXPERIENCE RATING

Some observers urge insurers to charge physicians premiums according to their claims "experience," with higher premiums for physicians with a history of many paid claims or expensive paid claims. Currently, the typical medical

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[96]Mr. Bovbjerg and Dr. Tancredi say their latest research in obstetrics cases lays these fears to rest. They say it shows such a system would be feasible; would remove the bulk of serious obstetrical injuries from the tort system; would achieve large administrative savings; and would not promote many expensive new cases.

malpractice insurer charges all physicians within a specialty the same premium rate, without regard to claims "experience."

As in other states, the cost of medical malpractice insurance premiums in Alaska is not based on the physician's claims "experience." Further, only in "very rare" circumstances are Norcal policies refused to physicians with multiple paid claims, according to a Norcal executive. The official said the company pays more attention to whether the standard of care that led to the claim was adequate than it does to the number of paid claims filed against a physician or hospital or to the cost of damages.

Frank Sloan of Vanderbilt University and Robert Hunter, consumer advocate and president of National Insurance Consumer Organization in Alexandria, Virginia, support the concept of experience rating. John Rolph, a RAND statistician, however, finds paid-claims are only moderately accurate predictors of a physician's future propensity to generate claims. The observations of these analysts are summarized below.

Past Claims Linked to Future Claims

Dr. Sloan says evidence that medical malpractice losses are concentrated among only a few physicians--his study showed 87 percent of losses by 6 percent of physicians--is "clear indication" that past experience predicts future experience. In the article describing his study, Dr. Sloan takes pains to note that "empirical evidence available up to now, including our study, does not demonstrate that claims experience is a valid indicator of physician quality, although it does correlate with future claims."[97]

But John Rolph, a senior statistician at the Rand Corporation, says in a 1991 article that past paid-claims history is an "only moderately accurate" predictor of future propensity to generate claims. He admits, however, that even if there are only a few targets of an experience-rating program, other physicians might find the potential stigma and economic consequences of premium surcharges substantial enough to cause them to improve their practice habits or suspend their medical practices. Dr. Rolph based his observations on a study of ten years of claims experience in New Jersey.[98]

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[97]Frank A. Sloan, "Experience Rating: Does It Make Sense for Medical Malpractice Insurance?" *AEA Papers and Proceedings*, May 1990, pp. 128-133; and Frank Sloan et al., "Medical Malpractice Experience of Physicians: Predictable or Haphazard?" *Journal of the American Medical Association*, Vol. 262, No. 23, December 15, 1989, pp. 3291-3297.

[98]John E. Rolph, "Merit Rating for Physicians' Malpractice Premiums: Only a Modest Deterrent," *Law and Contemporary Problems*, Vol. 54, No. 2., Spring 1991, pp. 65-86.

Automobile Insurance and Workers' Compensation are Experience Rated

Experience rating is universal in workers' compensation, according to Dr. Sloan. He points out that all state unemployment insurance programs use experience rating and that experience rating in automobile liability insurance is the rule in North America, Western Europe and Japan. Limited evidence shows that insureds behave differently if their future premiums depend on their past actions, he says.

In a joint hearing of the Alaska State House Labor and Commerce Committee and the House Judiciary Committee in April 1989, consumer advocate Robert Hunter said experience rating "would go a long way" toward reducing the price of medical malpractice premiums.[99] In a 1989 article for *Contingencies*, a monthly publication for actuaries, Mr. Hunter wrote that "good doctors, like good drivers should pay less, and doctors involved in malpractice, like drivers involved in accidents should pay more." Doctors who do fewer procedures should pay less than those who do many, he added.

Group-Based Experience Rating?

Dr. Sloan suggests group-based experience rating. He says experience rating a hospital medical staff would give more meaning to peer review. To avoid incentive to exclude physicians who treat high-risk patients, hospitals might subsidize the premiums of these doctors.

MEDIATION

Mediation, traditionally, is a voluntary, nonbinding process in which a neutral party works with parties to resolve a conflict in a mutually satisfactory settlement. Mediation is removed from the trial arena in several ways:

- **It is not bound by the rules of substantive or procedural law, or by the rules of evidence;**

- **The resolution may be a unique solution not governed by precedent; and**

- **Mediation does not emphasize right or wrong.**

Scholars say mediation works best when the parties have a significant prior relationship or an interest in continuing a relationship in the future. (One analyst points out that this relationship may be absent in the case of the

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[99]Statement of J. Robert Hunter before the joint hearing of the House Labor and Commerce Committee and the House Judiciary Committee of the Alaska State Legislature, April 25, 1989, p. 14.

emergency room physician or the obstetrician or pediatrician who steps in to care for a delivery mother and newborn with no previous prenatal care.)

Some states allow optional mediation of medical malpractice claims:

- In **MICHIGAN**, for example, mediation is a optional alternative (Michigan Compiled Law Section 600.4901).

- More commonly, a state's general mediation program covers medical malpractice as well. **TEXAS** is an example (Texas Civil Practice and Remedies Code Sec 154).

However, **WISCONSIN** since 1986 has required prelitigation mediation for all medical malpractice claims [Wisconsin Statutes Chapter 655 with statutory guidelines in 655.456(2)].[100] After analyzing mediated claims in that state between 1986 and 1988, one commentator concludes that the Wisconsin plan allows little direct party participation, results in few mediated settlements, does little to promote harmony and is "certainly not mediation in its classic sense."

The mandatory Wisconsin mediation plan is described below.

The Mediation Procedure in Wisconsin

The Wisconsin plan requires malpractice claimants to mediate in nonbinding prelitigation mediation sessions at which no records are kept and from which nothing is admissible in court.

Administration

The Office of the Director of State Courts administers the Wisconsin mediation program. Panels consist of three members (a lawyer chair, a physician or health professional with some expertise in the area of the claim, and a public member from a pool of names provided by the governor). Panel members have little training in mediation.

The Process

Medical malpractice claimants must file a request for mediation within 15 days of filing a malpractice claim (they can also request mediation before filing). The state's statute of limitations is suspended for the 90 days of mediation period and an additional 30 days following. Parties must share medical records

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[100] In 1986, the Wisconsin legislature replaced a pre-screening panel system, the Patient Compensation Panel, with the mandatory mediation panel.

and discovery is prohibited during mediation period. No records are kept at mediation panel sessions, sessions are nonbinding and nothing is admissible in court action.

Analysis of the Wisconsin Plan

A two-year research project has led one researcher to question the efficacy of the Wisconsin program. In a 1991 article in *Law and Contemporary Problems*, Catherine Meschievitz, assistant dean, Office of International Studies and Programs at the University of Wisconsin-Madison, said her study shows:

- fewer claims go each year to the mediation panel;
- most claims that do go to the panel are filed simultaneously in circuit court;
- the panel has a very low settlement rate;
- over 70 percent of claims going through mediation end up beginning the traditional civil litigation process in the state court system; and
- of 870 claims filed, only 35 cases reached settlement during or in conjunction with mediation session.

Dr. Meschievitz says mandatory mediation under the Wisconsin scheme may be unenforceable. Attorneys by-pass mediation by finding it impossible to mediate in 90 days and refusing to agree to extensions. "Conceivably, delay and last-minute cancellations are purposeful in order to avoid mediation," she says.

Perhaps panels act as an "early neutral evaluation" forum in which strengths and weaknesses of a case are assessed early, Dr. Meschievitz says. She says the panel office states that this is a primary function of the panels, especially in cases that do not settle, but she adds that there is no conclusive evidence that this early evaluation is occurring. It is also possible that lawyers are getting together and settling cases on their own. The high number of claims that settle before mediation or drop out of the system following mediation suggests that lawyers might be increasing negotiation ahead of time, avoiding the system. "Indeed recent information on the drop in the number of claims filed with the [mediation panel] leads one to surmise that practice patterns are being altered to avoid the [panel] altogether," the author states.

Dr. Meschievitz suggests two possible reforms to the Wisconsin mediation scheme. The first (a "rights-based" approach) would redefine the process from mandatory mediation to mandatory negotiated settlement. The second (an "interests-based approach) would attempt to create a truly mediative approach

with substantial input from the parties, as opposed to their attorneys. The approaches are summarized below.

- A "rights-based" approach would increase the opportunity for discovery. This would provide parties with more information earlier in the negotiation process. It would include a two-tiered process of panel hearings (a mandatory hearing after limited discovery and a second mandatory hearing prior to trial). A Note in a 1990 issue of the *Harvard Law Review* says rights-based mediation "focuses on the rights the disputants would have in court . . . and use those rights to develop parameters within which the parties might resolve the dispute."[101] The emphasis is on negotiation and settlement. This approach abandons any attempt to look like mediation.

- An "interests-based" approach would allow for mediation at any stage in the overall resolution process. It would require a neutral, trained mediator, perhaps assisted by a physician who specializes in the area of medicine relevant to the claim. It would allow mediation to take place in stages, before and after the beginning of formal litigation. It would provide for an "opt-out" process for claims less likely to benefit from mediation. The interests-based approach would assume that the primary goal is to provide parties an opportunity to reach a consensual agreement to the claim and reconcile their interests, needs and feelings in an informal procedure over which they have control, according to Dr. Meschievitz.

PRO: The Wisconsin mediation program may weed out frivolous or meritless claims before they get into the litigation system by allowing parties to heed negative readings from the panel.

CON: Dr. Meschievitz says, however, that it is just as possible that parties drop claims because they find mediation no help, or because they lack of adequate legal counsel or money.

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[101]Note, "Mandatory Mediation and Summary Jury Trial: Guidelines for Ensuring Fair and Effective Processes," *Harvard Law Review*, Vol. 103, p. 1086.

IMMUNITY

Some states have passed laws decreeing that a physician is immune from liability when rendering certain care, such as obstetrics, under certain circumstances, such as charity or volunteer care.

- **DELAWARE, NORTH CAROLINA** and **VIRGINIA** have laws limiting the liability of providers who perform charity or "drop-in" obstetrical care. Because the physician in the emergency room usually has not seen the patient before and has no record, and because women delivering in the emergency room may have had little or no prenatal care, the risk of complications can be high. The **VIRGINIA** law exempted physicians from liability for drop-in deliveries, even if the physician was paid for the service.

- A new **NORTH DAKOTA** law grants immunity from civil liability to health care providers who provide volunteer medical services at free clinics (HB 1262, 1991 Laws). An **ALABAMA** law provides immunity for any public or community service volunteer who cares for patients without compensation (HB 85, Act 439, 1991 Laws). In **MONTANA**, a licensed physician or registered nurse who gives instructions for medical care to a member of an emergency medical service with little or no compensation is not liable for damages for an injury resulting from the instructions (HB 938, Chapter 304, 1991 Laws). **NORTH CAROLINA** law protects providers who care for patients at a local health department or at a nonprofit community health center without compensation (HB 425, Chapter 655, 1991 Laws).

Limited liability does not protect a physician from claims due to willful acts or gross negligence. The Southern Regional Project on Infant Mortality reports that critics feel these laws unfairly curb indigent patients' right to sue for damages and that it could send a message to physicians that indigent patients can be treated with a different standard of care.[102]

OPTIONS CHOSEN BY THE SOUTHERN LEGISLATIVE CONFERENCE

The Southern Legislative Conference, supported by a grant from the federal government, has chosen several alternatives for legislative pursuit. The group met in North Carolina on December 12 and 13 of 1991. According to Shelly Gehshan of the Southern Regional Project on Infant Mortality (202-624-5897), the proposals include:

- subsidies for rural obstetrics providers based on North Carolina law;

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[102]"Medical Liability and Access to Obstetrical Care," *op. cit.*, p. 35.

- patient compensation plans with assessments on providers, based on Louisiana law;
- limited no-fault, based on Florida and Virginia neurological birth-related injuries laws;
- risk-reduction incentives, with reduced insurance for providers who pursue continuing education or risk reduction activities, based on Texas law;
- indemnification of providers under state contract, targeting providers who spend 20 percent of their worktime delivering babies for the public sector, based on Missouri law;
- prior-approval mechanisms, tightening up state insurance regulation, intended to smooth out the insurance industry cycle (although a spokesperson for the conference said "none work all that well"); and
- limited liability for "drop-in" care, deliveries and volunteer care, based on several states.

We hope this information is useful to you. If you have any questions, please contact this agency.

APPENDIX A

Selected Medical Malpractice Verdicts in Alaska

APPENDIX A

SELECTED MEDICAL MALPRACTICE VERDICTS IN ALASKA

Alaska medical malpractice court and jury verdicts have ranged from eight million dollars to a few thousand. Few jury verdicts have been against physicians alone; the majority have been won against hospitals (or hospitals and physicians).

To shed some light on the outcomes of Alaska malpractice claims, we present here a partial list of court and jury verdicts. The list is incomplete and may contain inaccuracies. It was compiled from state Supreme Court opinions, a database search by Jury Verdict Research in Ohio, a 1975 newspaper investigation into medical malpractice cases in Anchorage, conversations with lawyers, and the unpublished work of Dr. Rodman Wilson, an Alaska authority on medical liability cases. Some trials have been left off the list, not because they are deemed unimportant, but because it was difficult to obtain accurate information about them within the time constraints of this report.

The difficulty gathering information about the trend in Alaska's jury trials has made it clear that (absent a search of state superior court files) efforts to learn the trend in outcomes of the much larger body of medical malpractice claims, those which end in settlement, would be doomed. Settlements are not disclosed to the public and the amount of money paid and even the existence of the case can be sealed.

The following Alaska jury verdicts are arranged by amount of verdict:

- $8.3 million awarded after a bench trial in a 1983 obstetrics case involving a prolapsed umbilical cord. The case was filed in 1987 against a federal hospital in Anchorage and resolved in 1989 (*Heflin v. U.S.A.*, reported by Jury Verdict Research);

- $5.1 million awarded after a bench trial in a 1984 case involving a two-year-old with undiagnosed meningitis which caused brain damage. The case was filed in 1985 against a federal hospital in Bethel and resolved in 1988 (*Yako v. U.S.A.*, reported by Jury Verdict Research);

- $1.75 million awarded after a jury trial against an Anchorage hospital for failure to diagnose an aneurysm in the emergency room. The case was filed in 1986 (*Justice v. Humana* 3AN-86-122, reported by Jury Verdict Research);

- $1.175 million awarded by a jury in a Juneau case involving resuscitation of a child after drowning. The verdict was against a hospital (Expert Advisory Panel *Case No. 96* in Alaska State Medical Association files);

- $550,000 awarded after a jury trial against physicians at Faith Hospital in Glennallen involving loss of eyesight. The case was filed in 1987 (*Routt v. Physicians with SEND* 3AN-87-2033, reported by the Alaska State Medical Board);

- $500,000 awarded after a jury trial against an Anchorage physician after injuries from aggressive chemotherapy on a 19-year-old outpatient diagnosed with advanced testicular cancer. The case was filed in 1987 and payment made in 1991 (*Mellott v. Stewart* 3AN-87-5558, reported by the Alaska State Medical Board);

- $220,000 awarded by a jury in a case involving a mastectomy and insertion of a prosthesis with permanent disfigurement. A 1980 verdict against a surgeon and hospital; the $220,000 included a portion of the patient's costs and pre-judgment interest at 9.5 percent (Expert Advisory Panel *Case No. 49* in Alaska State Medical Association files);

- $210,000 awarded by a jury in a case involving facial paralysis after tests showed a tumor on a nerve. The 1989 verdict was against an Anchorage physician (*Germain v. Nathanson*);

- $170,000 awarded in 1972 after a bench trial before a federal judge involving a patient who entered a federal hospital in 1965 with complaints of a headache and hypertension and died (reported from a 1975 Anchorage newspaper study);

- $165,000 awarded by a jury in a 1967 case against an Anchorage doctor involving loss of a leg (reported from 1975 Anchorage newspaper study);

- $150,000 awarded after a bench trial in a 1971 case involving a patient who inhaled polyurethane (reported from 1975 Anchorage newspaper study);

- $50,000 awarded in 1982 against a physician in a case involving herniorraphy atrophy testis (Expert Advisory Panel *Case No. 74* in Alaska State Medical Association files);

- $45,000 awarded after a bench trial in a case involving complications after a thyroidectomy. Trial in 1961 with appeals and award in 1965 of $45,000 (*Patrick v. Sedwick*, reported by Alaska Supreme Court, 387 P.2d 294; 391 P.2d 453; and 413 P.2d 169);

- $44,726 awarded in 1989 in a case involving infected sinus after tooth extraction (*Holbrook v. McCarthy*, 3AN-87-9425, reported by Jury Verdict Research);

- $20,000 awarded in 1965 in a case involving burns during therapy (reported in a 1975 Anchorage newspaper study);

Among judge or jury verdicts in favor of the defendant physician or hospital were:

- *Poulin v. Zartman*, an Anchorage case which went to jury trial in 1973 after a premature baby was blinded by oxygen treatment (reported in 1975 and 1976 Alaska Supreme Court opinions 542 P.2d 251 and 548 P.2d 1299);

- *Priest v. Lindig*, a Fairbanks case which went to jury trial after a patient alleged that a chronic condition in her leg was caused by failure to diagnose a wound (reported in 1978 and 1979 Alaska Supreme Court opinions 583.2d 173 and 591 P.2d 1299);

- *Baker v. Warner* at Valley Hospital in Palmer, after a nine-day jury trial in which the wife of a man who died of Darvon and alcohol alleged the death was due to a doctor's negligence (reported in a 1982 Supreme Court opinion, 654 P.2d 263);

- *Bunting v. U.S.A.*, a bench trial in which the federal judge found no negligence in the emergency services by a Coast Guard physician after an airplane pilot was rescued by helicopter from 40 degree waters near Kodiak (reported in a 1989 Ninth Circuit Court opinion, 884 F.2d 1143 9th Circuit);

- *Vaughan (?) v. Providence*, a jury trial involving an Anchorage patient who burned herself while attempting to get out of restraints in her hospital bed (reported by Jury Verdict Research, 3AN-85-9845);

- *Cox v. Wichman*, a jury trial involving an Anchorage patient who alleged negligence after a severe ankle fracture become infected. The case was resolved in 1984 (reported by Jury Verdict Research, Anchorage Superior Court 79-6548);

- *Case No. 1B*, Expert Advisory Panel, jury verdict for physician and hospital. The case involved a fatal myocardial infarction and a Ketchikan patient who died the day he left a hospital emergency room where he appeared asymptomatic (reported in an unpublished memorandum by Dr. Rodman Wilson);

- *A 1961 jury verdict* for the doctor in a case involving a pin driven through the hip socket into the abdomen. The case was appealed and later settled out of court with a $30,000 payment to the patient (reported from an Anchorage newspaper study of Anchorage medical malpractice claims);

- *A 1967 jury verdict* for the doctor after a three-week trial in a case involving a one-day old baby who contracted spinal meningitis (reported from an Anchorage newspaper study of Anchorage medical malpractice claims);

- *Case No. 16*, Expert Advisory Panel, involving surgery which the panel thought was "unskillful." The Fairbanks jury exonerated the physician. The case was remanded on appeal. Later surgery and a secret memorandum showed injury had occurred, and the case was settled out of court for about $250,000 (reported in an unpublished memorandum by Dr. Rodman Wilson); and

- *Case No. 38*, Expert Advisory Panel, with a jury verdict for the doctor. The case involved ankle surgery (reported in an unpublished memorandum by Dr. Rodman Wilson).

APPENDIX B

Medical Malpractice Litigation in Alaska: 1960 - 1975

APPENDIX B

MEDICAL MALPRACTICE LITIGATION IN ALASKA: 1960-1975

The number of medical malpractice lawsuits filed in Alaska rose in the 1960s, as did the cost of malpractice premiums. Alaska doctors were more likely to be sued than were their colleagues in other states and they were also more likely to be uninsured. The malpractice ills of the mid-1970s led the legislature to change the law in the hopes of improving medical care and controlling the amount of damages in medical malpractice settlements and verdicts.

Alaska Physicians Going "Bare"

Thirty years ago, few U.S. physicians had ever faced a malpractice claim. The chances were higher for Alaskans, however. In the 1960s, one Alaska physician in four had been the target of a malpractice claim, compared to one physician in six nationwide (Alaska ranked third in the nation).[1]

Settlements

Most Alaska medical malpractice cases of the era were settled out of court. Some Alaska settlements were very large for the times, although large sums were the exception. The largest known settlement was $476,000 in a 1972 case involving orthopedic surgery which left a woman paralyzed (no suit was filed). The list that follows was taken from a 1975 Anchorage newspaper series in which research was based on a search of Anchorage superior court files, followed by conversations with lawyers. Since settlements or settlement amounts may be kept secret, the list is not complete and may not be accurate. It shows the following out-of-court settlements against hospitals or physicians through 1974:[2]

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[1]James Delaney, "Malpractice Lawsuits in Alaska," *op. cit.*

[2]Information about medical malpractice settlements and verdicts in this appendix is from Maureen Blewett, "Malpractice: A Case History," *Anchorage Daily News*, a series printed in July and August, 1975. The author of that series is also the author of this report.

1957	Internal medicine	Error in prescription	$ 2,500
1957	Surgery	Leg amputated after surgery	$270,000
1958	Surgery	Hip pin punctured bladder	$100,000+
1959	Neurosurgery	Complication following angiogram	$ 30,000
1959	Surgery	Infection	$100,000
1960	Surgery	Complications following hip surgery	$100,000+
1962	Ob/gyn	Complications after birth of twins	$ 3,000
1962	Ortho surgery	Complications	$ 3,500
1963	General practice	Excessive antibiotics	$?
1964	General practice	Bridge work destroyed	$ 1,050
1965	General practice	Death during surgery for ulcer	$ 40,000
1966	Ortho surgery	Hand crippled	$ 7,000
1970	Ob/gyn	Bladder punctured during hysterectomy	$ 20,000
1970	General medicine	Misdiagnosis	$ 7,000
1970	Oral surgery	Patient died during anesthesia	$160,000
1971	Ob/gyn	Patient still pregnant after abortion	$ 3,000
1972	Surgery	Patient paralyzed after spinal fracture	$476,000
1972	General medicine	Failure to follow patient after drug administered	$ 14,000
1973	Surgery	Wife conceived after husband's vasectomy	$ 7,500
1974	Oral surgery	Damage to facial nerve	$ 19,000
1974	Physician	Umbilical hernia	$100,000

Among medical malpractice lawsuits settled for the doctor were a complaint after a hysterectomy (1959), an allegation of improper healing of fractured hand and arm (1966), a death after a patient was injured in an accident (1967), surgery for a dislocated ankle (1969) and a doctor's mistaken report of venereal disease (1970).

Bench and Jury Trials

Comparatively few Alaska medical malpractice cases were decided by judges and juries. Jury verdicts for the patient ranged up to $165,000 for the loss of a leg in a 1967 case and one bench verdict of $170,000 following a death in a federal hospital (1967). Meanwhile, juries found for the doctor in a 1967 verdict in a case involving a one-day old baby who contracted spinal meningitis and in a 1973 trial involving a baby injured during premature birth. See the appendix for a list of selected Alaska bench and jury trials.

Malpractice Insurance

In 1967, in Anchorage, $100,000/$300,000 coverage for the highest-risk physician cost $725 a year ($2,414 in 1992 dollars), while coverage for low-risk physicians was $59 ($196 in 1992 dollars).[3] In a 1968 letter to the state Division of Insurance, the president of the Alaska State Medical Association said premiums were "prohibitively costly," adequate insurance was "increasingly difficult" to obtain, and several physicians "are totally unable to secure any coverage even though they themselves have no record of suits against themselves."[4] Meanwhile, 8 percent of Alaska physicians were uninsured, compared to 6 percent in the U.S.[5]

Nationwide, the rapid increase in the number of malpractice claims and the size of jury awards began to attract media attention. The U.S. Senate held hearings in 1969 and in 1971, President Nixon told the Secretary of Health, Education and Welfare to create a study commission to collect empirical information about malpractice. The commission concluded that malpractice insurance was readily available and that no crisis existed. The ink that printed this anodyne conclusion had barely dried when the crisis of the mid-1970s began.

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[3]James Delaney, "Malpractice Lawsuits in Alaska," *op. cit.*, pp. 408-409.

[4]James A. Lundquist, M.D., President, Alaska State Medical Association, letter to William W. Fritz, Director, Division of Insurance, Department of Commerce, Juneau, Alaska, July 31, 1968.

[5]The number of malpractice claims and lawsuits prompted medical malpractice defense attorney James Delaney of Anchorage to conjecture that Alaska might lead all other states in percentage of claims against doctors. James Delaney, "Malpractice Lawsuits in Alaska," *op. cit.*, p. 408.

Insurers, trying to keep pace with the cost of defending and paying for a rising number of claims, were raising the price of malpractice insurance premiums; limiting the amount they would pay in damages if a physician were found negligent; switching from occurrence to claims-made coverage;[6] and, in some cases, simply refusing to sell malpractice insurance at all. By the mid-1970s, the medical malpractice insurance market and physicians in Alaska and the nation were in an uproar.

In Alaska in 1975, a heart surgeon reacted by closing his practice. He told the *Anchorage Daily News* that he wouldn't risk being sued for $1 million when his malpractice insurance would pay only $300,000. Lloyds of London quietly narrowed its liability and then pulled out of the malpractice liability market all together. One in four Anchorage physicians said they were practicing without insurance. Radiation therapy was curtailed and an insurance broker predicted million dollar awards.[7]

In 1976, lawmakers stepped in to set up a public corporation to sell malpractice insurance to providers (Medical Indemnity Corporation of Alaska, or MICA).[8] They also passed legislation to improve the quality of medical care, cut down on the number of malpractice lawsuits, and limit the size of damages awarded. In the mid-1980s, legislators again passed tort reforms amid spiraling premiums, payments and health care costs.

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[6]An occurrence policy covers all claims arising out of care given while the physician was covered by the policy, no matter when in the future the claim is brought. A claims-made policy covers only those injuries that occurred and claims filed during the policy period. A claims-made policy first written in 1992 will cover claims filed in 1992, but not earlier. It will cover events that occurred in 1992 but are not brought until 1994, for example, only if the physician has continued coverage through 1994. The statute of limitations allows adults to file claims within two years after the event and children within two years after the age of majority. A physician who wants to continue coverage after a claims-made policy ends must purchase "tail" coverage.

[7]*Anchorage Daily News, op. cit.*

[8]In testimony before the House Judiciary committee (January 23, 1976) Dr. Rodman Wilson of Anchorage said Alaska neurosurgeons were paying $62,000 a year for malpractice insurance, more than $1,000 a week and some $500 a procedure. He estimated that only one of every 20,000 Alaska patients sues for malpractice and that malpractice expenses were affecting health care in the state for the 19,999 Alaskans who do not sue but who also have a right to good care.

APPENDIX C

List of Medical Malpractice Claims 1977 - 1989
MICA and MIEC

APPENDIX C
MICA CLAIMS (LAWSUITS AND FORMAL CLAIMS ONLY) BY REPORT DATE, ALASKA
Alaska, 1977–1989 (1)
Current as of September 30, 1989

	Defendant	File #	Closed	Payment ($)	Expenses ($)
REPORTED IN 1977					
Lawsuits	Hospital	77–012	6/30/81	200,000	11,288
	Physician	77–010	6/30/79	150,000	11,453
	Physician	78–014	6/30/81	50,000	774
	Physician	76–003	3/31/78	25,000	697
	Physician	76–001	9/30/83	0	62,367
	Hospital	77–008	6/30/82	0	23,605
	Physician	77–011	3/31/78	0	1,550
	Hospital	76–004	12/14/77	0	0
Claims	Physician	77–007	12/31/78	7,500	1,240
	Hospital	76–002	9/30/83	0	48,353
	Physician	77–002	6/30/78	0	168
	Physician	78–003	12/31/78	0	62
	Hospital	77–004	12/14/77	0	0
TOTAL	13			432,500	161,557
REPORTED IN 1978					
Lawsuits	Physician	78–009	6/30/81	55,000	12,576
	Hospital	78–001	3/31/81	10,000	11,720
	Facility/Physician	78–010	9/30/80	0	5,070
	Hospital	78–002	6/30/83	0	9,434
	Physician	78–005	3/31/79	0	1,644
	Physician	78–011	9/30/82	0	61,894
	Hospital	79–017–03	6/30/82	0	14,777
	Hospital	78–004	3/31/79	0	0
Claims	Hospital*	78–006	see note belo	35,426	0
	Hospital	78–013	3/31/79	0	379
	Hospital	79–015–01	3/31/79	0	0
TOTAL	11			100,426	117,494

Note: Case No. 78–006 was closed 9/78; reopened & filed 1988; the statute of limitations ends 5/98

* = Pending
Payment = money paid by carrier on behalf of provider
Expenses = legal fees, expert witness costs, computer research costs.

(1) Includes lawsuits and formal claims (defined as "formal written demands") only. Other incidents reported to the carrier are not included in this list

APPENDIX C

MICA CLAIMS (LAWSUITS AND FORMAL CLAIMS ONLY) BY REPORT DATE, ALASKA

Alaska, 1977–1989 (1)

Current as of September 30, 1989

	Defendant	File #	Closed	Payment ($)	Expenses ($)
REPORTED IN 1979					
Lawsuits	Hospital	79–021–07	9/30/81	45,000	18,666
	Physician	80–026–03	6/30/81	2,000	9,921
	Physician	79–020–06	9/30/82	0	10,195
	Physician	80–031–08	9/30/81	0	6,863
	Hospital	79–23–09	9/30/83	0	4,050
	Hospital	79–019–05	9/30/82	0	2,292
Claims	Hospital	79–016–92	4/3/79	0	1,090
	Physician	79–018–04	9/30/79	0	0
TOTAL	8			47,000	53,077
REPORTED IN 1980					
Lawsuits	Hospital	08–041–18	9/30/83	220,000	85,268
	Physician	80–028–05	6/30/87	75,000	4,057
	Physician	80–027–04	8/1/85	43,750	19,234
	Hospital	80–038–15	6/30/82	0	4,170
	Hospital	80–032–09	6/30/83	0	13,632
	Physician	80–037–14	6/30/82	0	3,208
	Physician	80–036–13	3/31/85	0	30,282
	Physician	80–029–06	9/30/85	0	39,427
Claims	Physician	80–025–02	6/30/81	50,000	3,438
	Physician	80–035–12	6/30/81	45,000	2,064
	Physician	80–024–01	9/30/81	6,711	1,550
	Hospital	80–039–16	12/31/81	0	1,765
	Hospital	80–034–11	12/31/82	0	444
	Hospital	80–040–17	9/30/81	0	405
TOTAL	14			440,461	208,944

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APPENDIX C
MICA CLAIMS (LAWSUITS AND FORMAL CLAIMS ONLY) BY REPORT DATE, ALASKA
Alaska, 1977–1989 (1)
Current as of September 30, 1989

	Defendant	File #	Closed	Payment ($)	Expenses ($)
REPORTED IN 1981					
Lawsuits	Physician	81–049–08	3/31/82	142,500	35,688
	Hospital	81–052–11	6/30/83	25,000	83,249
	Physician	81–046–05	6/30/83	20,000	3,739
	Hospital	81–043–02	3/31/85	0	3,845
	Hospital	81–045–04	6/30/82	0	4,328
	Physician	81–060–19	9/30/84	0	977
	Hospital	81–047–06	6/30/83	0	6,219
Claims	Physician	81–054–13	9/30/82	2,500	204
	Facility	81–058–17	12/31/82	0	885
	Physician	81–053–12	6/30/82	0	0
	Hospital	81–057–16	3/31/83	0	9,965
	Hospital	81–044–03	12/31/81	0	976
	Physician	81–050–09	6/30/82	0	784
	Physician	81–055–14	6/30/82	0	1,163
TOTAL	14			190,000	152,022
REPORTED IN 1982					
Lawsuits	Physician	82–081–21	3/31/85	229,964	11,395
	Hospital	82–065–05	5/20/87	150,000	24,913
	Physician	82–067–07	5/20/87	150,000	21,933
	Physician	82–071–11	6/30/84	80,000	9,941
	Physician	82–073–13	9/30/84	80,000	4,940
	Hospital	82–085–25	12/31/84	80,000	13,385
	Physician	82–069–09	12/31/84	50,205	15,234
	Hospital	82–070–10	12/31/84	50,205	15,227
	Physician	82–074–14	9/30/85	50,000	28,476
	Hospital	82–084–24	6/30/86	46,505	25,307
	Physician	82–079–19	9/30/85	15,000	13,142
	Hospital	82–076–16	3/31/86	7,750	3,542
	Physician	83–061–91	3/31/85	0	11,939
	Hospital	82–066–06	12/31/84	0	4,340
	Hospital	82–062–22	9/30/84	0	3,929
	Physician	82–068–08	6/30/84	0	9,419
	Physician	82–072–12	6/30/84	0	3,159
	Physician	82–078–18	3/31/86	0	672
	Physician	82–077–17	3/31/86	0	2,417
	Physician	82–062–02	6/30/82	0	1,686
Claims	Physician	82–075–15	9/30/83	100,000	3,935
	Physician	83–088–03	9/30/83	25,000	2,274
	Hospital	82–063–03	6/30/82	2,445	710
	Hospital	82–064–04	6/30/83	0	5,362
	Physician	82–080–20	3/31/83	0	1,814
TOTAL	25			1,117,074	239,091

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APPENDIX C
MICA CLAIMS (LAWSUITS AND FORMAL CLAIMS ONLY) BY REPORT DATE, ALASKA
Alaska, 1977-1989 (1)
Current as of September 30, 1989

	Defendant	File #	Closed	Payment ($)	Expenses ($)
REPORTED IN 1983					
Lawsuits	Hospital	83-112-27	3/31/86	750,000	13,206
	Physician	83-091-06	6/30/85	550,000	32,664
	Physician	83-090-13	12/31/84	333,665	25,379
	Physician	83-106-21	8/1/85	99,335	73,124
	Hospital	83-089-04	9/30/85	98,000	44,208
	Physician	83-094-09	12/31/84	7,000	8,839
	Physician	83-105-20	6/30/86	6,500	30,067
	Hospital	83-099-14	12/31/84	3,000	813
	Physician	83-092-07	9/30/84	0	6,095
	Physician	83-100-15	6/30/85	0	46,458
	Hospital	83-107-22	12/31/84	0	6,393
	Hospital	83-093-08	9/30/84	0	9,681
	Hospital	83-101-16	5/8/85	0	4,079
	Physician	83-103-18	6/30/85	0	32,683
	Physician	83-113-28	12/31/86	0	41,049
	Physician	83-095-10	5/30/87	0	4,449
	Hospital	83-090-05	7/31/87	0	55,774
	Facility	83-096-11	12/31/86	0	55,857
Claims	Physician	83-111-26	9/30/84	112,500	11,756
	Facility	83-110-25	3/31/84	2,000	570
	Hospital	83-007-02	3/31/83	1,800	406
	Physician	83-104-19	3/31/84	0	547
	Hospital	83-109-24	3/31/84	0	1,300
	Physician	83-006-01	6/30/83	0	0
	Physician	83-097-12	3/31/87	0	21,654
TOTAL		25		1,963,800	527,051

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APPENDIX C
MICA CLAIMS (LAWSUITS AND FORMAL CLAIMS ONLY) BY REPORT DATE, ALASKA
Alaska, 1977–1989 (1)
Current as of September 30, 1989

	Defendant	File #	Closed	Payment ($)	Expenses ($)
REPORTED IN 1984					
Lawsuits	Physician	84–130–15	2/1/89	1,910,582	246,132
	Hospital	84–137–22	12/13/88	1,750,500	395,253
	Physician	84–116–01	3/31/86	503,625	18,266
	Physician	84–132–17	10/15/87	190,000	36,359
	Physician	84–121–06	12/31/86	170,000	14,983
	Physician	84–170–55	10/4/88	99,628	31,906
	Physician	84–134–19	3/31/87	75,000	58,321
	Physician	84–138–23	8/31/87	58,321	37,470
	Physician	84–131–16	10/15/87	35,000	67,672
	Physician	84–133–18	8/1/85	32,000	19,506
	Hospital	84–122–07	12/31/86	30,000	3,695
	Physician	84–141–26	8/31/87	25,200	7,506
	Physician	84–117–02	3/31/87	12,500	74,676
	Physician	85–184–14	3/31/86	3,750	2,322
	Hospital	84–154–39	9/15/89	3,000	7,446
	Physician	84–145–300	3/31/86	0	0
	Physician	84–129–14	12/19/88	0	144,951
	Physician	84–145–30A	10/11/87	0	614
	Hospital	84–145–30E	10/11/87	0	0
	Physician	84–140–25	6/30/85	0	3,632
	Physician	84–145–30C	10/11/87	0	0
	Hospital	84–120–05	12/31/84	0	1,312
	Hospital	84–158–43	3/31/86	0	3,709
	Hospital	84–145–30D	10/11/87	0	0
	Physician	84–136–21	12/13/88	0	106,352
	Physician	84–144–29	12/31/85	0	3,998
	Physician	84–156–41	6/30/87	0	21,998
	Physician	84–153–38	1/31/88	0	0
	Hospital	84–150–35	3/31/86	0	0
	Physician	84–120–13	11/12/86	0	7,696
	Hospital	84–135–20	5/15/87	0	15,559
	Physician	84–119–04	9/30/84	0	2,854
Claims	Physician	84–143–28	3/31/86	312,500	12,170
	Physician	84–149–34	12/31/86	186,667	2,501
	Physician	84–166–51	3/31/85	20,000	0
	Hospital/Physician	84–155–40	3/31/85	8,371	0
	Hospital	84–142–27	2/6/85	8,174	0
	Physician	84–118–03	8/23/84	7,803	1,110
	Facility	84–124–09	11/26/85	7,500	0
	Physician	85–211–41	6/30/86	831	0
	Physician	84–157–42	6/30/85	0	0
	Physician	84–151–36	3/31/85	0	1,480
TOTAL		42		5,450,952	1,351,449

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APPENDIX C

MICA CLAIMS (LAWSUITS AND FORMAL CLAIMS ONLY) BY REPORT DATE, ALASKA

Alaska, 1977–1989 (1)

Current as of September 30, 1989

	Defendant	File #	Closed	Payment ($)	Expenses ($)
REPORTED IN 1985					
Lawsuits	Hospital/Physician	85–227–57	12/18/88	2,770,897	124,447
	Physician	85–203–33A	6/30/88	2,200,000	13,046
	Physician	85–197–27A	6/11/87	400,000	24,179
	Physician	85–214–44	9/30/87	175,000	10,878
	Physician	85–195–25	6/11/87	163,500	39,417
	Physician	85–201–31A	12/16/88	75,000	53,925
	Physician	85–192–22	12/29/88	50,000	37,045
	Physician	85–191–21	10/20/88	50,000	78,421
	Physician	85–222–52	4/25/89	45,000	8,317
	Hospital	85–201–31C	12/16/88	25,000	52,005
	Physician	85–198–28	3/31/87	25,000	15,576
	Physician	85–210–40	3/15/88	20,000	21,642
	Physician	85–216–46B	7/22/87	0	1,245
	Physician	85–220–50A	7/28/86	0	0
	Physician	85–216–46C	7/22/87	0	1,245
	Physician	85–204–34A	12/31/87	0	2,068
	Hospital	85–213–43	4/28/89	0	2,568
	Physician	85–181–11	6/30/86	0	3,927
	Physician	85–204–34B	12/3/87	0	2,170
	Hospital	85–999–063	5/15/89	0	8,589
	Physician	85–204–34C	12/3/87	0	296
	Physician	85–201–31B	10/30/88	0	4,903
	Physician	85–216–46A	7/22/87	0	1,245
	Physician	85–201–31D	6/30/88	0	5,237
	Physician	85–178–08	3/31/87	0	2,337
	Physician	85–182–12B	6/3/88	0	553
	Physician	85–207–37	6/30/86	0	861
	Physician	85–225–55	12/31/86	0	2,501
	Physician	85–220–500	7/28/86	0	0
	Physician	84–164–49	7/2/88	0	32,330
	Hospital	85–182–12A	6/3/88	0	6,544
	Physician	85–183–13	7/30/88	0	10,360

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APPENDIX C
MICA CLAIMS (LAWSUITS AND FORMAL CLAIMS ONLY) BY REPORT DATE, ALASKA
Alaska, 1977–1989 (1)
Current as of September 30, 1989

1985 Continued	Defendant	File #	Closed	Payment ($)	Expenses ($)
Claims	Physician	85–218–48	12/24/86	800,000	6,497
	Physician	85–190–20	12/31/85	100,000	2,307
	Physician	85–186–16	12/31/85	45,000	1,436
	Physician	85–180–10	6/30/86	35,000	0
	Physician	85–223–53	3/31/86	20,000	0
	Physician	85–251–23	10/30/87	10,000	3,788
	Physician	85–175–05	6/30/86	2,529	0
	Hospital	85–187–17	3/31/86	848	27
	Physician	85–197–27B	6/3/88	0	8,486
	Physician	85–224–54A	9/16/87	0	0
	Physician	85–215–45	12/19/88	0	0
	Physician	85–176–06	12/31/85	0	319
	Physician	85–172–02	9/30/85	0	1,158
	Physician	85–177–07	12/31/85	0	275
	Hospital	85–221–51	12/3/87	0	0
	Physician	85–226–56B	6/8/87	0	0
	Physician	85–179–09	8/10/87	0	1,162
	Physician	85–173–03	6/30/85	0	0
	Hospital/Physician	85–999–069	1/16/88	0	857
	Physician	85–212–42C	11/7/87	0	365
	Physician	85–208–38	8/28/86	0	0
	Physician	85–226–56A	6/8/87	0	0
	Hospital	85–224–54C	9/16/87	0	0
	Hospital	85–185–15	12/31/85	0	1,217
	Physician	85–174–04	6/30/85	0	0
	Physician	85–206–36	6/30/87	0	0
	Hospital	85–212–42B	11/7/87	0	365
	Physician	85–224–54B	9/16/87	0	0
	Physician	85–212–42A	11/7/87	0	606
TOTAL		61		7,012,774	597,242

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APPENDIX C
MICA CLAIMS (LAWSUITS AND FORMAL CLAIMS ONLY) BY REPORT DATE, ALASKA
Alaska, 1977–1989 (1)
Current as of September 30, 1989

	Defendant	File #	Closed	Payment ($)	Expenses ($)
REPORTED IN 1986					
Lawsuits	Physician*	86-230-10	NA	628,211	88,231
	Physician*	86-314-86	NA	300,000	72,651
	Physician*	86-232-04B	NA	170,992	105,252
	Physician*	86-232-04C	NA	170,992	103,492
	Physician*	86-232-04A	NA	88,621	24,077
	Physician*	86-232-04A	NA	88,621	24,068
	Physician	86-239-11A	4/17/89	300,000	9,186
	Physician	86-230-028	6/11/87	100,000	11,024
	Physician	86-230-02A	6/11/87	100,000	10,886
	Physician	86-234-06	3/31/87	12,500	18,501
	Physician	86-237-09	3/24/88	0	17,672
	Physician	86-252-24A	12/29/88	0	0
	Physician	86-328-100	2/10/89	0	3,379
	Physician	86-289-81	7/3/86	0	0
	Physician	86-233-05B	6/30/86	0	0
	Physician	86-360-132	9/15/89	0	198
	Physician	86-233-05A	6/30/86	0	121
	Physician	86-229-01	7/31/88	0	24,479
	Hospital	85-999-077	4/15/89	0	997
	Physician	86-252-24C	12/29/88	0	0
	Hospital	86-374-146	12/16/88	0	0
	Physician	86-252-24B	12/29/88	0	0
Claims	Physician	86-244-16	6/10/86	512,750	1,639
	Physician	86-242-14A	12/16/88	112,500	17,565
	Physician	86-246-18	10/10/86	5,995	0
	Physician	86-236-08	12/4/86	5,000	0
	Physician	86-241-13	9/16/86	4,786	0
	Physician	86-258-30	3/31/87	2,285	0
	Physician	86-235-07	12/18/86	2,007	200
	Physician	86-256-28	3/31/87	600	0
	Physician	86-254-26	3/31/87	476	100
	Physician	86-250-22A	3/31/87	0	0
	Hospital	86-250-22B	3/31/87	0	0
	Physician	86-255-27	8/8/88	0	10
	Physician	86-240-12	5/31/88	0	301
	Physician	86-259-31	10/28/87	0	0
	Physician	86-245-17	1/5/87	0	0
	Physician	86-246-19	10/30/87	0	1,573
TOTAL		38		2,606,336	535,602

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Expenses = legal fees, expert witness costs, computer research costs.

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APPENDIX C
MICA CLAIMS (LAWSUITS AND FORMAL CLAIMS ONLY) BY REPORT DATE, ALASKA
Alaska, 1977–1989 (1)
Current as of September 30, 1989

	Defendant	File #	Closed	Payment ($)	Expenses ($)
REPORTED IN 1987					
Lawsuits	Physician	87–437–27	10/30/88	49,357	2,439
	Physician	87–485–75	10/30/88	49,357	2,177
	Hospital	87–482–72	2/26/88	20,108	33,727
	Physician	87–491–81	6/9/87	0	0
	Physician	87–438–28	12/19/88	0	0
	Facility	87–556–146	11/30/87	0	0
	Physician	87–469–59	8/12/88	0	220
	Physician	87–557–147	6/30/88	0	1,273
	Physician	87–567–157	6/27/88	0	0
	Physician	87–444–34	2/10/88	0	0
	Hospital	87–557–147	6/30/88	0	0
Claims	Hospital	87–424–14	10/20/88	185,000	19,133
	Physician	87–544–134	9/3/88	15,000	2,608
	Physician	87–416–06	3/9/87	1,843	0
	Facility	87–532–122	9/9/87	223	0
	Physician	87–425–15	9/30/87	0	0
	Physician	87–574–164	12/19/88	0	0
	Physician	87–571–161	4/11/88	0	0
	Physician	87–427–17	8/7/87	0	0
	Physician	87–419–09	1/16/88	0	0
	Hospital	87–425–15B	9/30/87	0	0
	Facility	87–439–79	1/19/88	0	2,103
	Physician	87–526–116	4/11/88	0	50
	Physician	87–435–25	8/24/87	0	1,743
	Hospital	87–572–162	9/12/88	0	260
	Physician	87–490–80	10/26/87	0	0
TOTAL		26		320,888	65,733

* = Pending
Payment = money paid by carrier on behalf of provider
Expenses = legal fees, expert wit[illegible] computer research costs.

(1) Includes lawsuits and formal cla[illegible] as "formal written demands") only. Other incidents reported to the carrier are not included in this list

APPENDIX C
MICA CLAIMS (LAWSUITS AND FORMAL CLAIMS ONLY) BY REPORT DATE, ALASKA
Alaska, 1977–1989 (1)
Current as of September 30, 1989

	Defendant	File #	Closed	Payment ($)	Expenses ($)
REPORTED IN 1988					
Lawsuits	Physician	88–610–31	12/18/88	0	3,218
	Physician	88–660–81	8/9/89	0	0
Claims	Physician	88–999–096	9/18/89	48,003	4,758
	Physician	88–644–65	11/4/88	3,000	0
	Hospital	88–642–63	9/27/88	310	0
	Physician	88–591–12	12/19/88	0	0
	Physician	88–584–05	3/31/88	0	0
	Physician	88–598–19B	8/25/88	0	0
	Physician	88–595–16	3/22/88	0	0
	Hospital	88–598–19A	8/25/88	0	0
	Physician	88–667–88	--	0	265
	Physician	88–599–21	12/19/88	0	0
	Physician	88–599–20B	6/27/88	0	46
TOTAL	13			51,313	8,287
REPORTED IN 1989					
Claims	Physician*	89–706–32	NA	5,500	1,438
	Physician*	89–730–56A	NA	2,438	0
	Physician*	89–730–56B	NA	2,438	0
TOTAL	3			10,376	1,438

* = Pending
Payment = money paid by carrier on behalf of provider
Expenses = legal fees, expert witness costs, computer research costs.

(1) Includes lawsuits and formal claims (defined as "formal written demands") only. Other incidents reported to the carrier are not included in this list

Source: MICA computer run: "Current as of September 30, 1989," provided to the Legislative Liability Task Force; on file with the state legislative library

Prepared by the Legislative Research Agency, March 1992 (91.222AP).

APPENDIX C
MIEC CLAIMS (ALL CLAIMS) BY REPORT DATE, ALASKA 1980–1989

Specialty	Claim Number		Closed	Payment	Expenses
REPORTED IN 1980					
Surg	7001561–M		3/23/82	0	1,150
NeurSurg	7001781–M		10/17/86	0	0
Opth	7001786–M		3/8/83	0	0
TOTAL		3		0	1,150
REPORTED IN 1981					
N.Surg	7002031–M		6/11/85	125,000	14,479
Ortho	7002219/X		6/11/85	0	0
Part/Corps/	7002220–X		6/11/85	0	0
Peds	7002218–M		10/20/86	0	0
G.Surg	7002305–M		10/17/86	0	0
Ortho	7002432–M		10/21/86	0	0
TOTAL		6		125,000	14,479
REPORTED IN 1982					
Anesth	7002509–M		2/16/89	885,575	52,973
Part/Corp	7002510–X		2/16/89	885,575	41,975
Orthopedics	7002811–M		4/22/83	0	1,437
Otolaryngology	7002672–M		2/12/87	446,165	66,997
Cardiology	7003833–X		10/29/85	34,838	14,077
Int Med	7003094–M		10/29/85	104,013	8,453
G.Surg	7003095–X		10/29/85	0	0
Orthopedics	7002924–M		10/20/86	0	0
Urology	7003079–M		10/6/86	0	1,346
Orthopedics	7003128–M		9/14/87	755,747	40,929
Part/Corp	7003767–X		9/14/87	0	686
TOTAL		11		3,111,913	228,873
REPORTED IN 1983					
Ortho	7004808–M		3/9/89	0	16,033
Neurology	7004465–M		3/18/86	6,500	11,946
Ped Card*	7004647–M		NA	0	0
G.Surg*	7004337–M		NA	0	0
Oto	7003349–M		4/10/84	1,000	0
IntMed	7003823–M		7/28/86	0	1,765
NeurSurg	7003557–M		7/21/89	0	355,090
Neur	7003558–X		7/21/89	0	2,962
Ortho	7004504–M		10/6/86	0	590
Ortho	7003923–M		3/3/86	0	0
TOTAL		10		7,500	388,386

* = Pending
Payment = money paid by carrier on behalf of provider
Expenses = legal fees, expert witness costs, computer research costs.

(1) Includes all claims: those reported by provider, formal written claims and lawsuits

APPENDIX C
MIEC CLAIMS (ALL CLAIMS) BY REPORT DATE, ALASKA 1980–1989

Specialty	Claim Number		Closed	Payment	Expenses
REPORTED IN 1984					
Anesth	7003935–M		4/7/88	0	122,945
Ortho	7003925–M		3/29/88	275,000	33,693
Part/Corp	7003926–X		3/29/88	0	18,359
Ortho	7004903–M		8/29/88	0	0
NeurSurg	7003996–M		11/17/86	0	0
Neur	7003997–X		11/17/75	0	0
IntMed	7004792–M		12/1/88	0	5,601
RadiolDiag	7003999–M		12/16/85	7,500	3,725
Ped	7004062–M		10/1/86	0	1,213
IntMed*	7004354–M		NA	0	0
Ortho	7004421–M		3/4/86	848	147
RadiolDiag	7004420–M		10/26/87	250,000	29,232
Part/Corp	7005166–X		10/26/87	0	11,111
NeurSurg*	7004874–M		NA	0	0
IntMed*	7004875–X		NA	0	0
NeurSurg*	7005045–X		NA	0	0
IntMed*	7005046–X		NA	0	0
PlasSurg	7004417–M		10/8/87	0	367
TOTAL		18		533,348	226,393
REPORTED IN 1985					
Ortho	7004429–M		2/6/87	0	0
CardSurg	7004464–M		9/23/87	0	0
GenSurg	7004714–M		12/7/88	0	718
Ortho	7004540–M		12/9/87	0	0
IntMed	7004787–M		4/25/89	0	3,662
Derm	7004721–M		12/16/87	0	0
Ob/Gyn	7005284–M		4/26/88	0	0
IntMed*	7005028–X		NA	0	0
Ortho*	7004649–M		NA	0	0
Ortho*	7004650–X		NA	0	0
Peds	7004872–M		7/24/89	0	2,113
Ortho	7004978–M		5/17/88	0	352
IntMed	7004695–M		11/7/89	0	48
Card	7004698–X		11/7/89	0	0
Otol	7004696–X		11/7/89	0	0
CardSurg	7004697–X		11/7/89	0	0
IntMed	7004699–X		11/7/89	0	0
Gastro	7004715–M		1/4/88	0	0
GSurg	7004912–M		4/27/88	0	0
IntMed	7004913–X		4/27/88	0	0
FamPract	7004747–M		11/13/87	3,070	135
Part/Corp	7004880		2/12/88	0	0
NeurSurg	7004873–M		6/12/87	0	0
Urol	7004769–M		6/3/86	0	1,300
IntMed	7004899–M		4/26/88	0	0

* = Pending
Payment = money paid by carrier on behalf of provider
Expenses = legal fees, expert witness costs, computer research costs.

(1) Includes all claims: those reported by provider, formal written claims and lawsuits

APPENDIX C
MIEC CLAIMS (ALL CLAIMS) BY REPORT DATE, ALASKA 1980–1989

Specialty	Claim Number	Closed	Payment	Expenses
1985 (Continued)				
IntMed	7004789–M	9/23/88	0	0
CardSurg	7004895–M	10/10/88	0	14,056
GSurg	7004896–X	10/10/88	0	16,101
Gastroent	7004902–X	8/17/87	0	0
Anesth	7004901–M	8/17/87	349	400
Card*	7006047–X	NA	0	0
CardSurg*	7005195–M	NA	0	0
CardSurg*	7005196–X	NA	0	0
PedCard	7004924–M	6/23/88	0	121
PedCard	7004925–X	6/23/88	0	121
Ortho	7004879–M	7/25/88	0	0
IntMed	7004915–M	4/26/88	0	0
Anesth	7005074–M	7/6/88	0	0
Card	7004979–M	4/22/88	0	0
Ortho	7004961–M	6/14/88	0	0
Neur	7004919–M	6/8/89	173,076	54,516
IntMed	7004957–M	4/26/88	0	0
Anesth*	7004959–M	NA	0	0
Ophth	7005002–M	7/29/87	0	0
Ortho	7004960–M	4/27/88	0	0
Psych	7005003–M	1/21/88	0	0
Ortho	7004956–M	8/10/89	0	3
IntMed	7005073–M	6/14/88	0	0
Ortho*	7005476–M	NA	0	0
Ortho*	7005477–X	NA	0	0
Ortho	7005037–M	8/14/89	0	19,343
Ortho	7005038––X	8/14/89	0	502
ER	7005040–M	8/3/88	0	0
Peds	7005016–M	5/11/88	0	0
RadiolDiag	7005103–M	4/28/87	0	278
Otol	7005097–M	12/1/88	0	243
Derm	7005098–M	5/5/88	0	0
Ortho*	7005165–M	NA	0	0
GSurg	7005627–M	7/14/88	0	0
Otol*	7005184–M	NA	0	0
IntMed*	7005185–X	NA	0	0
Card	7005504–M	9/15/88	0	0
PlasSurg*	7005246–M	NA	0	0
PlasSurg	7005241–M	7/5/89	0	0
Card	7005268–M	8/11/88	0	0
ObGyn	7005273–M	4/5/89	0	750
ObGyn	7005351–M	1/4/88	0	0
IntMed	7005274–M	2/13/89	0	892
FamPract	.005308–M	2/1/88	0	0
FamPract	7005306–M	9/8/88	0	0
FamParct	7005305–M	7/14/88	0	0
RadioDiag	7005266–M	10/5/89	0	0
GSurg	7005309–M	1/5/89	0	0
TOTAL	73		176,495	115,654

(1) Includes all claims: those reported by provider, formal written claims and lawsuits

APPENDIX C
MIEC CLAIMS (ALL CLAIMS) BY REPORT DATE, ALASKA 1980–1989

Specialty	Claim Number	Closed	Payment	Expenses
REPORTED IN 1986				
Anesth	7005338–M	2/13/89	0	0
Ortho	7005339–M	12/6/88	0	0
Ortho	7005358–M	7/13/88	0	0
Peds	7005359–M	3/2/89	0	0
PlasSurg	7005408–M	12/1/88	0	0
IntMed	7005551–M	2/6/88	0	0
Ortho	7005552–X	12/6/88	0	0
Anesth	7006299–M	4/6/88	0	11,080
ObGyn	7005503–M	1/20/88	0	0
IntMed	7005553–M	4/5/89	0	0
Ortho*	7005598–M	NA	0	0
Ortho	7005571–M	3/1/89	0	0
Peds*	7005597–M	NA	0	0
PlasSurg*	7005578–M	NA	0	0
Derm	7005569–M	2/7/89	0	1,290
Ortho	7005594–M	4/4/89	0	0
PhyMed*	7005619–M	NA	0	0
Ortho	7005654–M	6/23/89	0	1,180
Anesth	7005655–X	6/23/89	0	0
IntMed	7005689–M	2/23/89	0	9,135
NeurSurg	7005658–M	1/5/89	0	385
PhysMed	7005927–M	4/20/89	0	0
Anesth	7005864–M	3/9/89	0	0
PlasSurg	7005926–M	12/6/88	0	1,991
GSurg	7005709–M	5/17/89	0	0
Ophth	7005856–M	6/23/89	0	0
Anesth	7005857–X	6/23/89	0	0
IntMed	7005858–X	6/23/89	0	0
Derm	7005745–M	2/7/89	0	0
Ortho	7005795–M	4/5/89	0	0
IntMed	7005796–X	4/5/89	0	0
IntMed	7005797–X	4/5/89	0	0
Ortho*	7005862–M	NA	0	0
ER*	7005883–X	NA	0	0
Ortho	7005792–M	7/5/89	0	0
ObGyn	7005868–M	7/6/88	0	0
IntMed	7005865–M	3/24/89	0	0
GSurg	7005865–M	3/24/89	0	0
Otol	7005854–M	10/2/89	380,316	145,664
Ortho*	7005953–M	NA	0	0
Ortho	7005937–M	5/17/89	0	579
Ortho*	7006064–M	NA	0	0
CardSurg	7005855–M	4/3/89	0	2,016
RadioDiag	7005935–M	5/17/89	0	0
Ortho*	7005946–M	NA	0	0
HandSurg*	7005947–X	NA	0	0

* = Pending
Payment = money paid by carrier on behalf of provider
Expenses = legal fees, expert witness costs, computer research costs.

(1) Includes all claims: those reported by provider, formal written claims and lawsuits

APPENDIX C
MIEC CLAIMS (ALL CLAIMS) BY REPORT DATE, ALASKA 1980–1989

Specialty	Claim Number	Closed	Payment	Expenses
1986 Continued				
Urol	7005936–M	6/23/89	0	0
NeurSurg	7005938–X	8/29/88	0	924
GSurg	7005950–M	12/1/88	0	0
Ortho	7005951–X	12/1/88	0	0
Ortho	7005949–X	7/11/89	0	0
IntMed	7005948–M	7/11/89	0	0
GSurg	7006078–M	10/26/89	0	0
GSurg*	7005968–M	NA	0	0
GSurg	7006056–M	6/23/89	0	3
Ortho	7006079–M	10/6/89	0	0
ER	7006080–X	10/6/89	0	0
Ortho	7006077–M	10/6/89	0	0
IntMed	7006060–M	8/1/88	0	0
PedCard	7006055–M	7/11/89	0	0
Ortho	7006076–M	7/12/89	0	0
GSurg	7006109–M	6/5/89	0	0
Anesth*	7006181–M	NA	0	0
CardSurg*	7006182–X	NA	0	0
Otol*	7006063–M	NA	0	0
GSurg*	7006071–M	NA	0	0
NeurSurg*	7006062–X	NA	0	0
NeurSurg*	7007092–X	NA	0	0
NeurSurg	7006058–M	1/5/89	0	912
GSurg	7006107–M	10/26/89	0	0
GSurg	7006108–M	7/11/89	0	0
IntMed*	7006437–M	NA	0	0
Ortho	7006183–M	12/6/88	0	0
RadioDiag*	7006188	NA	0	0
ObGyn	7006255–M	8/2/89	0	119
FamPract	7006257–M	9/12/89	0	3
Ortho	7006356–M	1/5/89	88,375	601
IntMed	7006313–M	10/26/89	0	12
IntMed	7006314–X	10/26/89	0	0
Ortho*	7006308–M	NA	0	0
TOTAL	80		468,691	175,894

* = Pending
Payment = money paid by carrier on behalf of provider
Expenses = legal fees, expert witness costs, computer research costs.

(1) Includes all claims: those reported by provider, formal written claims and lawsuits

APPENDIX C
MIEC CLAIMS (ALL CLAIMS) BY REPORT DATE, ALASKA 1980–1989

Specialty	Claim Number	Closed	Payment	Expenses
REPORTED IN 1987				
PedCard	7006301–M	7/24/89	0	3
Ortho*	7006307–M	NA	0	0
Otol*	7006335–M	NA	0	0
Anesth	7006382–M	10/26/89	0	0
Gastro	7006373–M	11/7/89	0	0
Ortho	7006381–M	11/7/89	0	3
Ortho	7006392–M	8/21/89	0	4
GSurg*	7006468–M	NA	0	0
RadioDiag	7006435–M	5/17/89	0	0
Part/Corp	7006418–M	12/6/88	0	13,987
ObGyn	7006414–M	11/1/89	0	0
PedSurg*	7006401–M	NA	0	0
ER	7006467–M	11/1/89	0	3
RadioDiag*	7006502–M	NA	0	0
IntMed*	7006566–M	NA	0	0
Part/Corp*	7006661–M	NA	0	0
IntMed	7006596–M	9/26/89	0	3
Ophth*	7006620–M	NA	0	0
ObGyn*	7006731–M	NA	0	0
RadioDiag*	7006664–M	NA	0	0
RadioDiag*	7006665–M	NA	0	0
IntMed*	7007409–X	NA	0	0
Derm*	7006728–M	NA	0	0
GSurg	7006726–M	7/19/89	0	2,610
Ortho*	7006837–M	NA	0	0
Gyn*	7006711–M	NA	0	0
Gastro*	7006730–M	NA	0	0
Derm*	7006727–M	NA	0	0
Ortho*	7006695–M	NA	0	0
Anesth*	7006729–M	NA	0	0
Peds*	7006641–M	NA	0	0
GSurg	7006885–M	7/13/89	425,000	8,559
NeurSurg	7006886–X	7/13/89	0	2,853
ER	7006887–X	7/13/89	0	3,003
Ortho	7007186–X	7/13/89	0	2,967
ObGyn*	7006838–M	NA	0	0
Ortho*	7006814–M	NA	0	0
Ortho*	7006815–X	NA	0	0
Derm*	7006860–M	NA	0	0
Card*	7007135–M	NA	0	0
ObGyn*	7006849–M	NA	0	0
Part/Corp*	7006850–X	NA	0	0
Anesth*	7006851–M	NA	0	0
IntMed*	7006906–M	NA	0	0
ER*	7007136–M	NA	0	0
Card*	7007952–M	NA	0	0

* = Pending
Payment = money paid by carrier on behalf of provider
Expenses = legal fees, expert witness costs, computer research costs.

(1) Includes all claims: those reported by provider, formal written claims and lawsuits

APPENDIX C
MIEC CLAIMS (ALL CLAIMS) BY REPORT DATE, ALASKA 1980–1989

Specialty	Claim Number	Closed	Payment	Expenses
1987 Continued				
ER*	7007017–M	NA	0	0
Peds*	7007745–M	NA	0	0
Ortho*	7007060–M	NA	0	0
IntMed*	7007041–M	NA	0	0
IntMed*	7007059–M	NA	0	0
'Ortho*	7007040–M	NA	0	0
Anesth	7007107–M	4/20/89	1,350	0
Ortho*	7007112–M	NA	0	0
IntMed*	7007111–M	NA	0	0
Gastro*	7007410–M	NA	0	0
NeurSurg*	7007399–M	NA	0	0
IntMed*	7007263–M	NA	0	0
Peds*	7007113–M	NA	0	0
IntMed*	7007210–M	NA	0	0
Ortho*	7007209–M	NA	0	0
Ophth	7007191–M	6/23/89	0	285
ObGyn*	7007223–M	NA	0	0
ObGyn*	7007224–X	NA	0	0
ObGyn*	7007225–X	NA	0	0
Ortho*	7007215–M	NA	0	0
TOTAL	66		426,350	34,280

* = Pending
Payment = money paid by carrier on behalf of provider
Expenses = legal fees, expert witness costs, computer research costs.

(1) Includes all claims: those reported by provider, formal written claims and lawsuits

APPENDIX C
MIEC CLAIMS (ALL CLAIMS) BY REPORT DATE, ALASKA 1980–1989

Specialty	Claim Number	Closed	Payment	Expenses
REPORTED IN 1988				
ObGyn*	7007235–M	NA	0	0
ObGyn*	7008034–M	NA	0	0
Otol*	7007984–M	NA	0	0
ObGyn*	7008035–M	NA	0	0
Ortho*	7007324–M	NA	0	0
Peds*	7007325–M	NA	0	0
IntMed*	7007354–M	NA	0	0
IntMed*	7007477–X	NA	0	0
RadioDiag	7007363–M	NA	0	0
Peds	7007413–M	NA	0	0
Ortho*	7007728–M	NA	0	0
Ortho*	7007387–M	NA	0	0
GSurg*	7007867–M	NA	0	0
Ortho	7007398–M	2/7/89	0	1,046
Peds*	7007411–M	NA	0	0
IntMed*	7007820–M	NA	0	0
ER*	7007517–M	NA	0	0
IntMed*	7007659–M	NA	0	0
Ortho*	7007518–M	NA	0	0
IntMed*	7007519–M	NA	0	0
Anesth*	7007593–M	NA	0	0
PedCard*	7007982–M	NA	0	0
Ortho*	7007955–M	NA	0	0
ER*	7007856–M	NA	0	0
Urol*	7007954–M	NA	0	0
Part/Corp*	7007594–M	NA	0	0
Otol*	7008130–M	NA	0	0
Anesth*	7007875–M	NA	0	0
Anesth	7007935–X	10/26/89	0	602
ObGyn*	7007729–M	NA	0	0
Part/Corp*	7007653–M	NA	0	0
GSurg*	7007652–M	NA	0	0
ObGyn	7007727–M	NA	0	0
Ortho*	7007709–M	NA	0	0
IntMed*	7007874–M	NA	0	0
Psych*	7007706–M	NA	0	0
CardSurg*	7007871–M	NA	0	0
PedCard*	7007872–X	NA	0	0
Otol*	7007870–M	NA	0	0
PhysMed*	7007788–M	NA	0	0
Ophth*	7008085–M	NA	0	0
GSury*	7007829–M	NA	0	0
Gastro*	7007822–M	NA	0	0
GSurg*	7007931–M	NA	0	0
ObGyn*	7007780–M	NA	0	0
Ortho*	7007840–M	NA	0	0

* = Pending
Payment = money paid by carrier on behalf of provider
Expenses = legal fees, expert witness costs, computer research costs.

(1) Includes all claims: those reported by provider, formal written claims and lawsuits

APPENDIX C
MIEC CLAIMS (ALL CLAIMS) BY REPORT DATE, ALASKA 1980–1989

Specialty	Claim Number	Closed	Payment	Expenses
1988 Continued				
Anesth*	7007841–M	NA	0	0
NeurSurg*	7007783–M	NA	0	0
NeurSurg*	7007789–X	NA	0	0
GSurg*	7007824–M	NA	0	0
Anesth*	7007857–M	NA	0	0
IntMed*	7007821–M	NA	0	0
Ophth*	7007925–M	NA	0	0
Ophth*	7007873–M	NA	0	0
PlasSurg*	7008125–M	NA	0	0
NeurSurg*	7007966–M	NA	0	0
NeurSurg*	7007967–X	NA	0	0
Otol*	7007934–M	NA	0	0
Ortho*	7007930–M	NA	0	0
Part/Corp*	7007919–M	NA	0	0
Ophth*	7007926–X	NA	0	0
Ortho	7007946–M	NA	0	0
Anesth*	7007947–X	NA	0	0
Ortho*	7007983–M	NA	0	0
Card*	7007953–X	NA	0	0
Peds*	7008032–M	NA	0	0
Ortho*	7008030–M	NA	0	0
Ortho*	7008031–M	NA	0	0
Ortho*	7008225–M	NA	0	0
Part/Corp*	7008107–M	NA	0	0
PhysMed*	7008108–X	NA	0	0
ObGyn	7008008–M	10/26/89	5,000	1,919
PhysMed*	7008106–M	NA	0	0
GSurg*	7008057–M	NA	0	0
Part/Corp*	7008033–M	NA	0	0
Card*	7008359–M	NA	0	0
Anesth*	7008184–M	NA	0	0
PlasSurg*	7008109–M	NA	0	0
GSurg*	7008237–M	NA	0	0
Anesth*	7008183–M	NA	0	0
GSurg*	7008190–M	NA	0	0
Peds*	7008351–M	NA	0	0
GSurg*	7008242–M	NA	0	0
TOTAL	83		5,000	3,567

* = Pending
Payment = money paid by carrier on behalf of provider
Expenses = legal fees, expert witness costs, computer research costs.

(1) Includes all claims: those reported by provider, formal written claims and lawsuits

APPENDIX C
MIEC CLAIMS (ALL CLAIMS) BY REPORT DATE, ALASKA 1980–1989

Specialty	Claim Number	Closed	Payment	Expenses
REPORTED IN 1989				
Ortho*	7008343–x	NA	0	0
ObGyn*	7008324–X	NA	0	0
ObGyn*	7008323–M	NA	0	0
IntMed*	7008238–M	NA	0	0
ObGyn*	7008276–M	NA	0	0
PhysMed*	7008254–M	NA	0	0
Part/Corp*	7008255–X	NA	0	0
ER*	7008286–M	NA	0	0
HandSurg*	8008287–X	NA	0	0
PlasSurg*	7008307–M	NA	0	0
ER*	7008321–M	NA	0	0
ER*	7008322–X	NA	0	0
RadioDiag*	7008360–M	NA	0	0
GSurg*	7008367–X	NA	0	0
Ortho*	7008368–X	NA	0	0
TOTAL	15		0	0

* = Pending
Payment = money paid by carrier on behalf of provider
Expenses = legal fees, expert witness costs, computer research costs.

(1) Includes all claims: those reported by provider, formal written claims and lawsuits

Source: MIEC computer run: "Alaska: Prepared November 21, 1989," provided to the Legislative Liability Task Force; on file with the state legislative library

Prepared by the Legislative Research Agency, March 1992 (91–222A2).

APPENDIX D

Anchorage Medical Malpractice Lawsuits 1988 - 1992

APPENDIX D
Medical Malpractice Lawsuits Filed with Expert Advisory Panel
Anchorage, August 1988 – February 1992

	Number	Date Filed	Panel Findings	Disposition
1	88–08644	8–88	Report due 3–16–92	
2	88–11350	11–88	No injury (appropriate medical care)	Dismissed by stipulation
			Injury (non–consensual care)	
3	88–12398	No Information		
4	89–00741	1–89	No report filed	Dismissed
5	89–00985	2–89	No report filed	Awaiting trial
6	89–02697	4–89	Still trying to compose panel	
7	89–05966	7–89	Panel waived by stipulation	Summary judgment for defendant
8	89–06782	8–89	No injury	Dismissed against hospital and doctor
				Trial on remaining claims set for April 1993
9	89–07154	8–89	No injury	Dismissed by stipulation prior to trial
10	89–07242	8–89	Awaiting nominees for panel	
11	89–07267	8–89	No injury	Dismissed before answer of Industrial Indemnity
				Claims of one plaintiff dismissed by stipulation
				Case pending
12	89–09183	11–89	---	Petition for review in Supreme Court
13	89–09303	11–89	Injury occurred	Dismissed by stipulation prior to trial
			Same M.D. as No. 55	
14	89–09704	11–89	No report filed	Dismissed by stipulation
15	89–09957	12–89	No injury	Case pending further proceedings
16	90–01852	3–90	No panel appointed: case to federal court	
17	90–02493	3–90	---	Dismissed for lack of prosecution
18	90–02708	No information		
19	90–09850	12–89	No medical injury	Judgment in favor of one defendant
			Same M.D. as No. 60	Case still pending as to other defendants
21	90–03229	No information		
22	90–03486	No information		
23	90–03512	5–90	No injury	Dismissed by stipulation prior to trial
24	90–04236	5–90	No injury as to one M.D. defendant	Case involving hospital dismissed prior to report
			Injury occurred as to two M.D. defendants	Case involving other defendants open and pending
25	90–05688	7–90	Injury occurred as to both defendants	Dismissed by stipulation
			One M.D. is same as 91–10427	
26	90–05772	7–90	No panel appointed	Dismissed by stipulation
				Settlement agreement: $60,000 to plaintiff
27	90–05963	7–90	No injury	Dismissed by stipulation
28	90–06831	8–90	Awaiting nominees to panel	
29	90–08693	10–90	Nominees requested 2–20–92	
30	90–08759	10–90	No injury	Dismissed by stipulation
31	90–08975	10–90	No injury as to defendants	Set for trial January 1993
32	90–09060	11–90	Apenl appointed 2–20–92	
			Report due 4–20–92	
33	90–10046	12–90	No medical injury	Summary judgment to defendant
				Dismissed by stipulation
34	90–10502	12–90	Panel waived	Dismissed by stipulation
35	91–00640	No information		
36	91–01071	2–91	Panel report due 3–5–92	
37	91–01156	2–91		No action since complaint filed
38	91–01372	2–91	Negligence	This case dismissed by stipulation
			Same M.D. as Nos. 39,56,66,67,68	
39	91–01686	3–91	No panel	Dismissed by stipulation
			Same M.D. as 38,56,66,67,68	
40	91–01789	3–91	Panel waived	Hospital defendant dismissed by stipulation
			Same M.D. as No. 57	
41	91–02755	4–91	Awaiting appointment order	
42	91–02755	4–91	Awaiting appointment	
	91–03242	4–91		No action since complaint filed

APPENDIX D
Medical Malpractice Lawsuits Filed with Expert Advisory Panel
Anchorage, August 1988 – February 1992

	Number	Date Filed	Panel Findings	Disposition
43	91-03435	4-91	Panel report due 3-20-92	
44	91-04748	6-91	Awaiting appointment	
45	91-04798	6-91	Injury occurred	Awaiting further proceedings
46	91-05258	6-91	--- Same M.D. as No. 49	Case not at issue*
47	91-05406	6-91	---	Case at issue. Awaiting word to proceed
48	91-06689	8-91	Injury occurred	Awaiting further proceedings
49	91-06723	3-91	--- Same M.D. as No. 46	Case not at issue*
50	91-06977	8-91	---	Case not at issue*
51	91-07174	8-91	Awaiting new nominees to panel	
52	91-07246	8-91	Awaiting nominees to panel	
53	91-07418	8-91	Questionable injury	Case pending trial setting
54	91-07611	10-91	Nominees to be requested	Case at issue**
55	91-08611	10-91	--- Same M.D. as No. 13	Case stayed 90 days from 1-21-92 per stipulation
56	91-09108	10-91	No panel requested as yet Same M.D. as Nos. 38,39,66,67,686	
57	91-09827	11-91	Awaiting nominees to panel Same M.D. as No. 40	
58	91-10041	11-91	Panel waived by court order	Case pending further proceedings
59	91-10160	12-91	Awaiting nominees to panel	
60	91-10427	12-91	Awaiting nominees to panel Same M.D. as No. 25	
61	91-10879	12-91	---	Case not at issue*
62	92-00859	1-92	---	Case not at issue*
63	92-01098	2-92	---	Case not at issue*
64	92-01398	2-92	---	Case not at issue*
65	91-08247	9-91	No panel appointed	
66	91-00740	1-91	--- Same M.D. as 38,39,56,67,68	Case dismissed by stipulation
67	91-01314	02-91	--- Same M.D. as 38,39,56,66,68	Case dismissed by stipulation prior to appointment of panel
68	91-04812	6-91	--- Same M.D. as 38,39,56,66,67	Dismissed by stipulation prior to appointment of panel
69	90-09580	11-90	---	Dismissed by stipulation prior to appointment of panel
70	89-07984	9-89	Injury occurred	Dismissed by stipulation
71	90-07319	8-90	No panel appointed	Summary judgment for defendant M.D. Governmental defendant dismissed; dismissal appealed

*Case not at issue:
**Case at issue:

Source: Diane Alford, State of Alaska Trial Courts, Third Judicial District, February 24, 1992

Prepared by the Legislative Research Agency, March 1992 (92.222A3)

THE FOLLOWING DOCUMENT HAS
NOT BEEN FILMED BUT IS
AVAILABLE IN THE ORIGINAL
FILE

Alaska State Legislature

Legislative Research Agency

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

November 29, 1989

MEMORANDUM

TO: Representative Dave Donley

ATTN: Ginger Baim

FROM: Patricia Young
Legislative Analyst

RE: Medical Malpractice Insurance Premiums
Research Request 90.124

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

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

Limiting Classifications of Physicians

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

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

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

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

Obstetrical Care Incentive Programs

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

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

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

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

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

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

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

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

Attachments

ATTACHMENT A

"How to Solve the Medical Malpractice Crisis"

HOW TO SOLVE THE MEDICAL MALPRACTICE "CRISIS"

By J. Robert Hunter

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

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

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

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

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

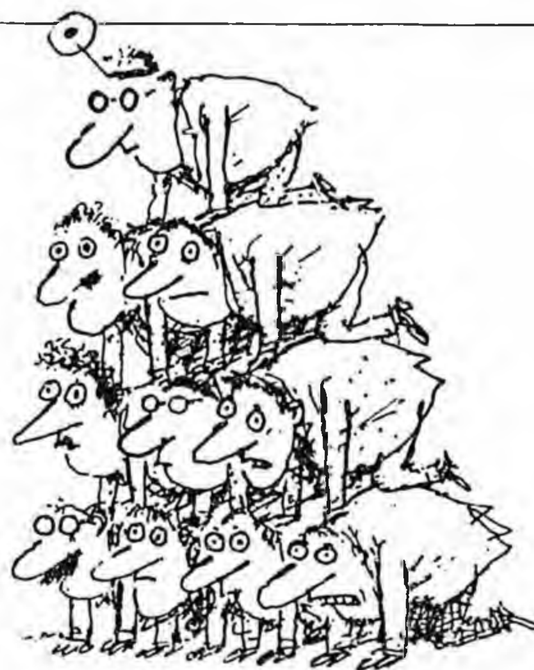
Here's another, rather telling, fact about the medical malpractice insurance business. Between 1977 and 1987, U.S. medical malpractice insurers took in more than five times as much in premiums as they paid out in claims, according to A.M. Best's. Then, too, when insurance companies say that they had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

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

Illustrations by Richard Thompson

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

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



Costs Aren't Allocated Fairly

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

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

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

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

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

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

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

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

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

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

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

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

Excessive Rates?

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

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

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

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

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

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

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

How to Lower Insurance Rates

1. Require insurance companies to experience-rate doctors.

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

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

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

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

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

4. Tighten state regulation of malpractice insurance.

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

5. Penalize frivolous suits and defenses.

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

6. Limit lawyer fees.

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

7. Focus on peer review.

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

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

BOARD OF GOVERNORS:
William O. Brock, Chairman
David J. Frazier, 1st Vice-Chairman
Frederick R. Hood, M.D., 2nd Vice-Chairman
David S. [illegible]rauman, M.D., Member At Large
Ronald W. Keller, M.D.
Renee Murray
Kim C. Smith, M.D.
C. Keith Campbell
Patricia L. Miles

ADMINISTRATIVE SERVICES:
Mary Pierce, Executive Director
Janet Sloan Johnston, Claim Manager
Penny Chmielewski, Risk Management Coordinator
Art Stanford, Underwriting Manager
Vickie Powell, Policyholder Services

MICA Medical Indemnity Corporation of Alaska

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

1989

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

Death or Total and Permanent Disability:

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

New Doctor Rule:

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

Claims Free Premium Discount:

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

Claims Experience Premium Surcharges:

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

Employee Coverages:

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

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

No additional premium charges are incurred for other employees.

Locum Tenens:

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

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

Part Time Practitioners:

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

Short Term Practice Situations:

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

Comprehensive General Liability Coverages:

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

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

Corporate/Partnership/Group Professional Liability:

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

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

Optional Shared Limits Professional Liability Group Coverage:

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

CLAIMS - MADE PREMIUM SCHEDULE

Effective January 1, 1989 **

LIMITS OF LIABILITY: EACH CLAIM AND ANNUAL AGGREGATE

	1st - 5th Years	$200,000/$600,000	$500,000/$1,000,000	$1,000,000/$2,000,000 $1,000,000/$3,000,000 *
CLASS 1				
1st year rates	Jan. 1, 1989	3,087	3,598	4,364
• 2nd year renewal rates	Jan. 1, 1988	4,532	5,644	7,269
• 3rd year renewal rates	Jan. 1, 1987	7,141	9,275	12,374
• 4th year renewal rates	Jan. 1, 1986	8,027	10,504	14,098
• 5th year renewal rates	Jan. 1, 1985	8,082	10,581	14,206
CLASS 2				
1st year rates	Jan. 1, 1989	4,477	5,396	6,740
• 2nd year renewal rates	Jan. 1, 1988	7,031	8,950	11,736
• 3rd year renewal rates	Jan. 1, 1987	11,515	15,161	20,441
• 4th year renewal rates	Jan. 1, 1986	13,029	17,256	23,376
• 5th year renewal rates	Jan. 1, 1985	13,125	17,387	23,560
CLASS 2-A *				
1st year rates	Jan. 1, 1989	6,066	7,451	9,45[illegible]
• 2nd year renewal rates	Jan. 1, 1988	9,886	12,728	16,840
• 3rd year renewal rates	Jan. 1, 1987	16,514	21,887	29,661
• 4th year renewal rates	Jan. 1, 1986	18,747	24,972	33,980
• 5th year renewal rates	Jan. 1, 1985	18,887	25,166	34,251
CLASS 2-B/3				
1st year rates	Jan. 1, 1989	7,655	9,506	12,168
• 2nd year renewal rates	Jan. 1, 1988	12,742	16,506	21,944
• 3rd year renewal rates	Jan. 1, 1987	21,514	28,613	38,880
• 4th year renewal rates	Jan. 1, 1986	24,465	32,688	44,584
• 5th year renewal rates	Jan. 1, 1985	24,650	32,944	44,942
CLASS 4				
1st year rates	Jan. 1, 1989	11,032	13,873	17,936
• 2nd year renewal rates	Jan. 1, 1988	18,810	24,535	32,790
• 3rd year renewal rates	Jan. 1, 1987	32,138	42,906	58,472
• 4th year renewal rates	Jan. 1, 1986	36,615	49,085	67,117
• 5th year renewal rates	Jan. 1, 1985	36,895	49,473	67,659
CLASS 4-A				
1st year rates	Jan. 1, 1989	12,422	15,671	20,311
• 2nd year renewal rates	Jan. 1, 1988	21,309	27,841	37,256
• 3rd year renewal rates	Jan. 1, 1987	36,512	48,791	66,539
• 4th year renewal rates	Jan. 1, 1986	41,617	55,837	76,395
• 5th year renewal rates	Jan. 1, 1985	41,938	56,279	77,013
CLASS 5				
1st year rates	Jan. 1, 1989	16,991	21,578	28,115
• 2nd year renewal rates	Jan. 1, 1988	29,519	38,703	51,931
• 3rd year renewal rates	Jan. 1, 1987	50,886	68,129	93,046
• 4th year renewal rates	Jan. 1, 1986	58,056	78,021	106,881
• 5th year renewal rates	Jan. 1, 1985	58,505	78,641	107,749

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

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

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

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

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

Discounts Per Limits of Liability

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

Installments - Deferred Payments:

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

PHYSICIAN'S RATE CLASSIFICATIONS

Class 1

Neurology

Psychiatry - excluding ECT;

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

Class 2

Neonatology

Opthalmology (Excluding Radial Keratotomy)

Physicians - minor surgery or assisting in major surgery. *
Applies to general practitioners and physician specialists who perform minor surgery (including catheterization) or assist in major surgery.

Class 2-A

Emergency Medicine

Class 3

Physicians who include obstetrical procedures as any part of their practice. (May still be indicated as class 2-B on policy:)

Physicians - major surgery *

Proctology

Otorhinolaryngology

Abdominal Surgery

General Surgery

Pediatric Surgery

Thoracic Surgery

Traumatic Surgery

Plastic and Reconstructive Surgery, excluding cosmetic surgery

Urology

Gynecology (No Obstetrics)

Class 4

Anesthesiology

Class 4-A

Physicians - major surgery

Therapeutic Radiology

Obstetrics - Gynecology

Cardiovascular Surgery

Hand Surgery

Plastic and Reconstructive Surgery, including cosmetic surgery

Vascular Surgery

Orthopedic Surgery, excluding total joint procedures, spinal surgery and insertion of prosthetic devices.

Class 5

Physicians - major surgery

Neurosurgery

Orthopedic Surgery, including total joint procedures, spinal surgery and insertion of prosthetic devices.

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

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

PROFESSIONAL LIABILITY COVERAGES

Explanation of Policy:

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

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

Cost:

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

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

Limits of Liability:

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

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

Tail Coverages:

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

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

Cost:

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

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

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

Retirement Benefit:

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

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

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

ATTACHMENT C
Medical Insurance Exchange of California
(MIEC) 1989 Coverage Classification and Premium Schedule

Medical Insurance Exchange of Californi

1989 Coverage Classification and Premium Schedule

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

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

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

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

Secretaries, Receptionists and Bookkeepers — No charge.

Optional Coverages:

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

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

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

Defense coverage for miscellaneous liability

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

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

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

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

MEDICAL INSURANCE EXCHANGE OF CALIFORNIA

ALASKA

CLAIMS MADE PROFESSIONAL LIABILITY PREMIUM SCHEDULE

EFFECTIVE AUGUST 1, 1989

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

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

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

MEDICAL INSURANCE EXCHANGE OF CALIFORNIA

ALASKA

CLAIMS MADE PROFESSIONAL LIABILITY PREMIUM SCHEDULE

EFFECTIVE AUGUST 1, 1989

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

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

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

ATTACHMENT D
Arizona and North Carolina Bills

Senate Engrossed House Bill

ISSUED BY
JIM SHUMWAY
SECRETARY OF STATE

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

Chapter 290
HOUSE BILL 2467

AN ACT

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

1 Be it enacted by the Legislature of the State of Arizona:
2 Section 1. Appropriation; purpose; exemption
3 A. The sum of one hundred ninety-five thousand dollars is
4 appropriated from the state general fund to the department of health
5 services for the purposes described in subsection B of this section.
6 B. The department shall identify areas in the state that are
7 underserved with regard to obstetrical services. For purposes of this
8 section, an area shall be considered underserved with regard to
9 obstetrical services if the area satisfies any of the following:
10 1. Fifty per cent or more of resident live-births occur outside the
11 city or town of residence.
12 2. Cities or towns where obstetric services are threatened with
13 discontinuance.
14 3. Cities or towns having a population of less than ten thousand
15 where prenatal services are not provided by a physician.
16 4. Cities or towns having a population of less than ten thousand
17 where obstetric backup services for a physician are not available.
18 5. Cities or towns where the average number of prenatal visits are
19 less than the state average.
20 C. The department shall identify those physicians who practice in
21 areas defined in subsection B of this section who meet the following:
22 1. Shall have current obstetrical delivery privileges at one or
23 more rural, non-federal hospitals.

1 2. Shall be a registered provider with the Arizona health care cost
2 containment system who has established a contract for obstetrical services
3 with at least one or more of the system's prepaid contractors.
4 3. The physician shall be licensed by the appropriate licensure
5 board.
6 D. Family physicians who perform less than fifty deliveries per
7 year and who are required to pay an additional premium to perform
8 obstetrical services shall be eligible to receive an amount not to exceed
9 five thousand dollars. Family physicians who perform more than fifty
10 deliveries per year and who are required to pay an additional premium to
11 perform obstetrical services shall be eligible to receive an amount not to
12 exceed ten thousand dollars. Obstetricians who are required to pay an
13 additional premium to provide obstetrical services shall be eligible to
14 receive an amount not to exceed ten thousand dollars. Payment of one-half
15 of the financial assistance identified in this section shall be contingent
16 upon receipt of the report required pursuant to subsection F of this
17 section. The second payment shall be paid upon receipt of the second
18 report required pursuant to subsection F of this section.
19 E. Physicians seeking financial assistance shall respond to the
20 department's notice within thirty days of receipt of such notice in a
21 format prescribed by the department. The department shall evaluate the
22 physician's request for financial assistance and shall classify the
23 requests according to the city or town's need for obstetrical services and
24 ability to meet all or at least one of the criteria specified in
25 subsection B of this section. The highest classification shall be
26 assigned to those cities or towns which meet all of the criteria specified
27 in subsection B of this section. The lowest classification shall be
28 assigned to those cities or towns which meet at least one of the criteria
29 specified in subsection B of this section. The department shall establish
30 contracts with those physicians whose requests are assigned the highest
31 classification. If funds remain available, the department shall proceed
32 in descending order to establish contracts with those physicians whose
33 requests have been assigned a lower classification until funding is
34 depleted.
35 F. The financial assistance awarded pursuant to subsection E of
36 this section shall be used for each physician who meets the qualifications
37 of subsection C of this section, is under contract with the department to
38 remain in practice in the rural area for the contract year and who
39 provides a report upon completion of one-half of the contract term and
40 upon conclusion of the contract to the department which identifies the
41 number of women to whom the physician has provided medical services during
42 delivery, the ages of the women, the number of prenatal visits each woman
43 received, the number of women who are at or below federal poverty
44 standard, the number of Arizona health care cost containment system
45 enrolled women served and the insurance status of the women. Contracts
46 pursuant to this section are exempt from the requirements of title 41,
47 chapter 23, Arizona Revised Statutes.

THE
FOLLOWING
DOCUMENTS
ARE
POOR
ORIGINAL
COPIES

1 G. The university of Arizona college of medicine shall examine the
2 adequacy of obstetrical services in rural underserved areas. The
3 university of Arizona college of medicine shall develop a plan which may
4 include the use of educational subsidies designed to overcome any
5 identified inadequacies in the delivery of obstetrical care or other
6 primary health care services in rural Arizona. The plan shall include
7 recommendations regarding educational subsidies, identification of funding
8 needs, identification of alternative funding sources and necessary
9 legislative action to implement the recommendations. The university of
10 Arizona college of medicine shall submit their report to the governor,
11 president of the senate and speaker of the house of representatives by
12 February 1, 1990.
13 H. The department shall submit a written report to the governor,
14 the president of the senate and the speaker of the house of
15 representatives on or before February 1, 1990 on the number of physicians
16 who have applied and the number of physicians who received financial
17 assistance provided pursuant to subsection E of this section. One year
18 from the effective date of this section, the department shall evaluate the
19 effectiveness of the financial assistance provided pursuant to this
20 section and shall on or before January 1, 1991, submit a written report of
21 its findings to the governor, the president of the senate and the speaker
22 of the house of representatives. The report shall include recommendations
23 regarding continuation of the financial assistance, the number of
24 physicians who received financial assistance who plan to continue
25 providing prenatal and delivery services in rural Arizona and legislative
26 action necessary to improve the control, distribution and cost
27 effectiveness of the financial assistance.
28 I. The appropriation made in this section is exempt from section
29 35-190, Arizona Revised Statutes, relating to lapsing of appropriations.

Approved by the Governor June 28, 1989.

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

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

Multi-county incorporations; cities; correction NOW: Rural physicians: financial assistance (H.B. 2437) - Chapter 280

Appropriates $155,000 from the state general fund to the department of health services (DHS) to provide financial assistance to rural allopathic and osteopathic physicians. The appropriation is exempt from lapsing.

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

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

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

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

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

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

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1987

H D

HOUSE DRH7342-LK659

Short Title: Rural Obstetrical Care Incentive (Public)

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

Referred to:

1 A BILL TO BE ENTITLED
2 AN ACT TO APPROPRIATE FUNDS TO THE DEPARTMENT OF HUMAN
3 RESOURCES TO ESTABLISH A PROGRAM TO COMPENSATE FAMILY
4 PHYSICIANS AND OBSTETRICIANS WHO AGREE TO PROVIDE
5 PRENATAL AND OBSTETRICAL SERVICES IN COUNTIES THAT ARE
6 UNDERSERVED WITH REGARD TO THESE SERVICES
7 Whereas, there are currently 22 counties in the State which have no
8 physicians to provide prenatal or obstetrical care in those counties, most of which are
9 rural counties; and
10 Whereas, there are 20 counties in the State in which more than half of
11 the expectant mothers must leave the county for obstetrical care because there are
12 not enough physicians in their home county to provide obstetrical care; and
13 Whereas, prior to 1985 nearly 500 family physicians in North Carolina
14 were providing obstetrical care; and
15 Whereas, after severe increases in liability insurance premiums, some in
16 excess of three hundred fifty percent (350%), the number of family physicians
17 providing obstetrical care has dropped to 189, and numerous obstetricians have
18 dropped that part of their practice; and

Whereas, it is in the interest of the State to provide quality prenatal and neonatal care and to provide access to health care for all its citizens; Now, therefore,

The General Assembly of North Carolina enacts:

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

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

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

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

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

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

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

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

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

GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 1989

S

S 8 0 PRINCIPAL CLERK

SENATE DRS7020-LK263(3/17)

Short Title: Rural Obstetrical Care Funds. (Public)

Sponsors: Senators Swain and Winner

Referred to:

1 A BILL TO BE ENTITLED
2 AN ACT TO APPROPRIATE FUNDS TO THE DEPARTMENT OF HUMAN
3 RESOURCES FOR THE RURAL OBSTETRICAL CARE INCENTIVE
4 PROGRAM.
5 The General Assembly of North Carolina enacts:
6 Section 1. There is appropriated from the General Fund to the
7 Department of Human Resources the sum of one million dollars ($1,000,000) for the
8 1989-90 fiscal year and the sum of two million dollars ($2,000,000) for the 1990-91
9 fiscal year to fund the rural obstetrical care incentive program.
10 The rural obstetrical care program shall compensate family physicians
11 and obstetricians who agree to provide prenatal and obstetrical services in counties
12 that are underserved with regard to these services. The Commission for Health
13 Services shall adopt rules determining the counties that are underserved with respect
14 to obstetrical care that are to be part of this program, the scope of the obstetrical
15 services that are to be provided by a physician for that physician to be eligible to
16 receive assistance under the program, and the amount and nature of the assistance to
17 be provided to eligible physicians. Specific rules issued by the Commission for
18 Health Services governing this program shall include:
19 (1) A physician who provides obstetrical care in a county that is
20 designated as being underserved for prenatal and obstetrical care

1 by the Commission for Health Services will be compensated for
2 either the difference between his premiums with obstetrical care
3 coverage and his premiums without obstetrical care coverage, or
4 six thousand five hundred dollars ($6,500), whichever is less;
5 (2) Physicians providing obstetrical care through an arrangement with
6 their local health department shall have the option of providing
7 the care at their offices or at the facilities of the health department
8 obstetrical clinic;
9 (3) No physician shall be required to assume management of the care
10 of any obstetrical patient if the level of care required for that
11 patient is beyond the professional competence of that physician.
12 (4) Physicians eligible for payment under this program shall be
13 licensed to practice medicine in this State;
14 (5) Participating physicians shall provide complete obstetrical care for
15 covered patients including prenatal care and delivery; provided,
16 however, physicians in a county without a facility for obstetrical
17 delivery are still eligible if they provide only prenatal care;
18 (6) The liability insurance rates for obstetrical care to be used to
19 determine compensation under this program shall be based on
20 obstetrical premiums of $1,000,000/$1,000,000 coverage at a mature
21 rate; and
22 (7) Any physician compensated under this program shall not refuse to
23 provide obstetrical care for any patient based on the patient's
24 economic status or ability to pay.
25 Sec. 2. This act shall become effective July 1, 1989.

THE FOLLOWING DOCUMENT HAS
NOT BEEN FILMED BUT IS
AVAILABLE IN THE ORIGINAL
FILE

Alaska State Legislature

Legislative Research Agency

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

November 29, 1989

MEMORANDUM

TO: Representative Dave Donley

ATTN: Ginger Baim

FROM: Patricia Young
Legislative Analyst

RE: Medical Malpractice Insurance Premiums
Research Request 90.124

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

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

Limiting Classifications of Physicians

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

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

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

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

Obstetrical Care Incentive Programs

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

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

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

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

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

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

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

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

Attachments

ATTACHMENT A
"How to Solve the Medical Malpractice Crisis"

HOW TO SOLVE THE MEDICAL MALPRACTICE "CRISIS"

By J. Robert Hunter

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

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

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

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

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

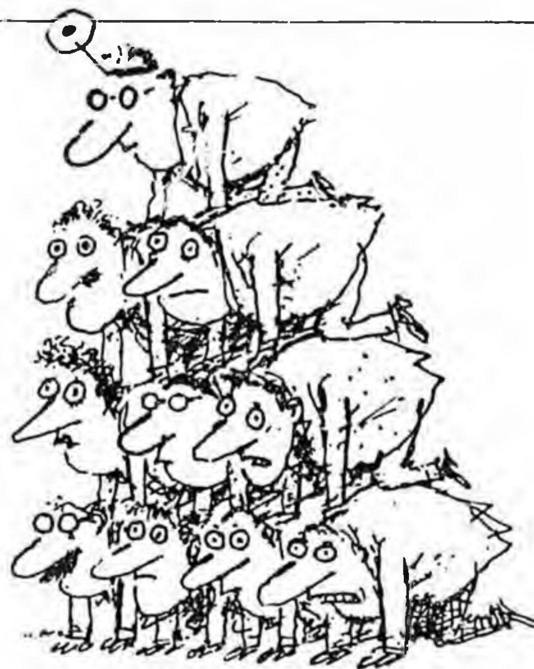
Here's another, rather telling, fact about the medical malpractice insurance business. Between 1977 and 1987, U.S. medical malpractice insurers took in more than five times as much in premiums as they paid out in claims, according to A.M. Best's. Then, too, when insurance companies say that they had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

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

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

Illustrations by Richard Thompson

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



Costs Aren't Allocated Fairly

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

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

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

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

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

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

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

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

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

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

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

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

Excessive Rates?

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

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

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

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

Nor would tort ref[illegible] that ubiquitously mentioned *deus ex machina*, be of [illegible]ch help.

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

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

How to Lower Insurance Rates

1. Require insurance companies to experience-rate doctors.

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

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

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

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

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

4. Tighten state regulation of malpractice insurance.

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

5. Penalize frivolous suits and defenses.

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

6. Limit lawyer fees.

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

7. Focus on peer review.

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

ATTACHMENT B

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

BOARD OF GOVERNORS:
William O. Brock, Chairman
David J. Frazier, 1st Vice-Chairman
Frederick R. Hood, M.D., 2nd Vice-Chairman
David S. Grauman, M.D., Member At Large
Ronald W. Keller, M.D.
Renee Murray
Kim C. Smith, M.D.
C. Keith Campbell
Patricia L. Miles

ADMINISTRATIVE SERVICES:
Mary Pierce, Executive Director
Janet Sloan Johnston, Claim Manager
Penny Chmielewski, Risk Management Coordinator
Art Stanford, Underwriting Manager
Vickie Powell, Policyholder Services

MICA Medical Indemnity Corporation of Alaska
ALEUT PLAZA OFFICE BUILDING
4000 OLD SEWARD HIGHWAY, SUITE 203
ANCHORAGE, ALASKA 99503
TELEPHONE (907) 563-3414

1989

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

Death or Total and Permanent Disability:

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

New Doctor Rule:

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

Claims Free Premium Discount:

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

Claims Experience Premium Surcharges:

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

Employee Coverages:

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

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

No additional premium charges are incurred for other employees.

Locum Tenens:

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

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

Part Time Practitioners:

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

Short Term Practice Situations:

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

Comprehensive General Liability Coverages:

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

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

Corporate/Partnership/Group Professional Liability:

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

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

Optional Shared Limits Professional Liability Group Coverage:

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