ALASKA LEGISLATURE COMMITTEE FILES 1993-1994 8672

7965 HOUSE LABOR & COMMERCE

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lawyer is likely to spend as an arbitrator each year is small. Many arbitrators might even be willing to contribute more time to the program voluntarily.

Finally, the long run capacity of the program is a significant concern. Under the present program policies and conditions, CAAP is strained to handle half of the First Circuit's tort cases within the 9 month deadline. The current supply of arbitrators is inadequate to handle all the tort cases eligible for arbitration if the comparison group were eliminated.

CONCLUSIONS

Hawaii's Court Annexed Arbitration Program appears to be meeting its goals of reducing litigant costs, increasing pace, and maintaining the satisfaction of participants. Although under the current operating procedures, it does not appear that CAAP could handle all the tort cases filed in Hawaii courts, the Judicial Arbitration Commission is working on this problem.

CAAP is delivering arbitration largely within the time frame prescribed by its rules, and is doing so to the satisfaction of the majority of lawyers. It clearly has succeeded in reducing pretrial discovery, and no other program can make that claim. After more comparison cases have closed, a later report will be able to provide data comparing pace, cost, and satisfaction in CAAP with regular litigation. To our knowledge, no other arbitration program in country claims to be reducing litigation costs; Hawaii leads the nation is this area.

GENERAL SURVEY RESULTS
SUMMARY

In November, 1988, we sent a special "general survey" to the 91 lawyers (an almost equal number of plaintiff and defense lawyers) who handled the greatest number of arbitration cases among the cases we surveyed. These 91 lawyers were involved in 84 percent of the cases we surveyed. 62 lawyers completed and returned the survey (a 68 percent response rate). Although this general survey does not ask about specific cases, it does represent very recent general opinions from the lawyers who are the most active in CAAP.

PACE & COST

The lawyers indicated that most cases in CAAP were completed faster and cost less than cases in regular litigation. Ninety-two percent of all lawyers thought CAAP was faster than regular litigation and 83 percent thought it was cheaper. Eight percent thought cases took about the same amount of time, and 17 percent thought cases cost about the same amount. Not a single plaintiffs' or defense lawyer thought CAAP was slower or more expensive than regular litigation.

SATISFACTION

Seventy-eight percent of all lawyers reported that they were satisfied with the program, and 29 percent were dissatisfied. A major difference in satisfaction was found between plaintiffs' lawyers and defense lawyers. Ninety-one percent of the plaintiffs' lawyers were satisfied with the program, but only 46 percent of the defense lawyers were satisfied.

CHANGES IN VALUE OF THE CASES

Lawyers were asked what effect arbitration has had on the settlement value of tort cases eligible for the program. Thirty-three percent of lawyers believed that the settlement value has remained the same, 35 % thought the impact was unclear, 7 percent thought value decreased, and 25 % thought the value increased. Again, the major differences are between plaintiffs' and defense lawyers. Only 14 percent (3 of 22) of plaintiffs' lawyers but 42 percent (8 of 19) defense lawyers thought values have increased. Dissatisfaction by the defense lawyers is correlated to the opinion that the value of cases has increased.

ARBITRATOR SERVICE

Forty-seven percent (28 of 60) of all lawyers and 55 percent (21 of 38) lawyers who have served as arbitrators said that arbitrators should be willing to be assigned two or more arbitration cases at one time.

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

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P.O. Box Y, State Capitol
Juneau, Alaska 99811-3100
Mail Stop 3100
(907) 465-3991

March 15, 1989

MEMORANDUM

TO: Representative Peter Goll

ATTN: Hayden Kaden

FROM: Karen Oakley KO
Legislative Analyst

RE: **Medical Malpractice Premiums Paid by Alaska Doctors**
Research Request 89.297

You asked how many doctors are in private practice in rural Alaska communities, and whether these doctors pay more for medical malpractice insurance than do other doctors. You also asked if the federal government pays medical malpractice premiums for the doctors it employs in Alaska.

In summary, there are only a handful of doctors in private practice living in rural Alaska communities. Medical malpractice premiums paid by Alaska doctors depend on the type of medicine practiced and the limits of liability chosen; the location of the practice does not directly affect premium cost. Liability for malpractice by federally-employed doctors is assumed by the federal government.

Geographic Distribution of Alaska Doctors

Currently, there are approximately 825 physicians working in Alaska. The Alaska State Medical Association (ASMA) Directory listed 827 doctors in Alaska in 1987. The Division of Occupational Licensing reported a similar number--833 doctors--with current licenses in August 1988.

Nearly 75 percent of doctors working in Alaska are in private practice. The major government employers of doctors in Alaska are the military, which employs 97 doctors, and the U.S. Public Health Service (PHS) (including the Indian Health Service), which employs 111 doctors. At least some of the PHS doctors are itinerants based in larger communities who travel to remote communities.

In Table 1, the number of doctors in private practice residing in each house election district is presented. We were not able to determine to what extent doctors in private practice provide services to communities other than the community in which the doctor resides. Conceivably, some private doctors living in urban areas travel to rural areas to provide services.

TABLE 1
NUMBER OF PRIVATE PHYSICIANS OF VARIOUS SPECIALTIES RESIDING IN EACH HOUSE ELECTION DISTRICT
(LIST RANKED BY THE NUMBER OF PRIVATE PHYSICIANS IN THE SPECIALTY)

		HOUSE ELECTION DISTRICT															
SPECIALTY	TOTAL	1	2	3	4	5	6	7-15	16	17	18-21	22	23	24	25	26	27
Family & General Practice	151	6		4	10	14	2	77	13		15				1	2	7
Internal Medicine	80	3		3	5	1		53			13						2
Pediatrics	44	2			2	1		26	2		10						1
Surgery	44	2		2	3	2		22	2		9						2
Obstetrics-Gynecology	42	1				1		29	3		8						
Orthopedic Surgery	41	2			2	1		24	1		10						1
Emergency Medicine	37				3	5		19	4		6						
Psychiatry	34	1			2			26			5						
Radiology	25	1			2	1		14	1		6						
Anethesiology	25	1				1		18	1		4						
Opthalmology	18				1	1		12			4						
Otolaryngology	14				1			9	1		3						
Pathology	12							8	1		3						
Cardiology	8							8									
Urology	7					1		4			2						
Neurology & Neurology Surgery	7							6			1						
Neonatal & Perinatal Medicine	7							7									
Dermatology	6				1			4			1						
Physical Medicine & Rehabilitation	4							4									
Occupational Medicine	4							4									
Acupuncture	2							2									
Sports Medicine	2							1			1						
Gastroenterology	2							2									
Family Therapy	2							1		1							
Public Health & Preventive Medicine	1							1									
Aerospace Medicine	0																
Primary Care	0																
TOTAL PRIVATE PHYSICIANS	619	19	0	9	32	29	2	381	29	1	101	0	0	0	1	2	13
TOTAL PHYSICIANS	827	24	1	19	36	29	2	496	29	3	138	4	6	0	17	7	16
PERCENT IN PRIVATE PRACTICE	74.8	79.2	0.0	47.4	88.9	100.0	100.0	76.8	100.0	33.3	73.2	0.0	0.0	0.0	5.9	28.6	81.3
PERCENT OF TOTAL IN PRIVATE PRACTICE		3.1	0.0	1.5	5.2	4.7	0.3	61.6	4.7	0.2	16.3	0.0	0.0	0.0	0.2	0.3	2.1

SOURCE: ALASKA STATE MEDICAL ASSOCIATION DIRECTORY (1987).

Prepared by the House Research Agency, March 1989 (89.297A).

These data indicate that very few doctors in private practice reside in rural areas. Four election districts that are generally considered to be rural (2, 22, 23, and 24) have no resident doctors in private practice.[1] The majority of doctors in private practice reside in Anchorage and Fairbanks (78 percent).

Twenty-four percent of all private doctors are in Family and General Practice. In those election districts with few resident private doctors, those doctors are typically in family practice. Most of the private specialists reside in Anchorage or Fairbanks.

For further information on the geographic distribution of doctors and other health care providers in Alaska, see House Research Memorandum 89.004, which is provided as Attachment A.

Medical Malpractice Premiums Paid by Alaska Doctors

Doctors employed by the federal government are not covered by medical malpractice insurance; instead, the federal government assumes liability for malpractice by its doctors. An individual who is injured by a federal government doctor in the normal course of the doctor's job may sue the federal government under the Federal Tort Claims Act. When the injured individual is successful in their claim against the government, damages are paid from a fund administered by the U.S. Department of Justice. Further information on medical malpractice coverage of federal government doctors is found in House Research Memorandum 87.097 (Attachment B).

Doctors in private practice obtain medical malpractice insurance from insurance companies.[2] According to the Alaska Division of Insurance Annual Report for FY 88, 22 insurance companies wrote medical malpractice insurance policies for doctors practicing in Alaska in that year. Attachment C, from the report, shows the percent of market share written by each company. A total of $14.4 million in direct premiums written was reported. Three companies accounted for 92.5 percent of the total dollar value of premiums written. These companies were the Medical Indemnity Corporation of Alaska (MICA), Medical Insurance Exchange of California (MIEC), and the Continental Casualty Company.

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[1]One election district, Election District 24, has no resident doctors.

[2]The state does not require proof of insurance from doctors licensed to practice medicine in Alaska, and it is possible that some doctors do not have medical malpractice insurance.

The MICA had 48.3 percent of the medical malpractice market in Alaska in FY 88. The MICA was established by the Alaska Legislature in 1976 in response to the liability insurance crisis occurring at that time which severely reduced the availability of medical malpractice insurance in Alaska and elsewhere.[3] The current premium schedule of the MICA is provided in Attachment D. The premium paid by a doctor depends upon the type of medicine the doctor practices and the limits of liability the doctor chooses. The MICA does not take the location of a doctor's practice into consideration in determining the premium.

The second largest provider of medical malpractice insurance to Alaska doctors is the MIEC. The MIEC is doctor-owned. The Alaska State Medical Association brought MIEC to Alaska around 1979 to provide doctors with a choice of insurance coverage. The current premium schedule of the MIEC is provided in Attachment E. As for the MICA, the premium schedule depends upon the doctor's specialty and limits of liability; the location of the doctor's practice is not taken into consideration.

In FY 88, the Continental Casualty Company, which is based in Chicago, wrote $1.6 million in direct medical malpractice premiums, for an 11 percent market share. According to Renee Smith, of the company, Continental uses the standard ISO rates in determining the premiums to charge Alaska doctors that insure with them.[4] She could not provide a premium schedule and was not sure how their rates compared with those of MICA or MIEC.

Premiums charged by both MICA and MIEC are based on actual Alaska loss experience data. Although none of the companies takes the precise location of the doctor's practice within Alaska into account when determining the premium, the doctor's location and the type of medicine practiced are often related; thus, the doctor's location may indirectly affect the doctor's medical malpractice insurance costs. Doctors practicing in rural areas are more likely to be generalists, rather than specialists. Rural doctors would therefore be more likely to be placed in the lower risk classifications and consequently pay less for medical malpractice insurance than specialized practioners.

* * *

I hope you find this information useful. If I can provide any further information, please let me know.

Attachments

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[3]For further information on the Medical Indemnity Corporation of Alaska, see House Research Memorandum 81.010.

[4]The ISO is one of the major ratings organizations.

ATTACHMENT A
House Research Memorandum 89.004

ATTACHMENT B
House Research Memorandum 87.097

ATTACHMENT C
Alaska Division of Insurance Annual Report FY 88
Companies Writing Medical Malpractice Insurance
Policies for Alaska Doctors

From Division of Insurance Annual Report for FY 88

PROPERTY AND CASUALTY MARKET SHARE
11 - MEDICAL MALPRACTICE

RANK	COMPANY NAME	PERCENT OF MARKET	DIRECT PREMIUMS WRITTEN
1	MEDICAL INDEMNITY CORP OF AK	48.32	6,937
2	MEDICAL INS EXCHANGE OF CALIFORNIA	33.27	4,777
3	CONTINENTAL CASUALTY CO	10.93	1,570
4	NATIONAL UNION FIRE INS CO OF PITTSB	3.04	437
5	ST PAUL FIRE & MARINE INS CO	1.13	163
6	AETNA CASUALTY & SURETY CO	.90	130
7	NATIONAL CHIROPRACTIC MUTUAL INS CO	.59	85
8	CHICAGO INS CO	.45	65
9	AMERICAN CASUALTY CO OF READING	.45	65
10	TRAVELERS INDEMNITY CO	.41	59
11	NATIONAL FIRE INS CO OF HARTFORD	.24	35
12	INS CO OF THE STATE OF PA	.07	11
13	RLI INS CO	.06	9
14	AMERICAN CONTINENTAL INS CO	.03	5
15	ALASKA PACIFIC ASR CO	.03	5
16	PACIFIC EMPLOYERS INS CO	.02	4
17	HARTFORD FIRE INS CO	.01	2
18	INTERSTATE INDEMNITY CO	.00	1
19	JEFFERSON INS CO OF NY	.00	1
20	ST PAUL MERCURY INS CO	.00	-1
TOTAL FOR TOP 20 RANKED INSURERS		99.95	14,360
TOTAL FOR ALL 22 INSURERS WRITING THIS LINE		99.93	14,356

ATTACHMENT D
Medical Indemnity Corporation of Alaska
1989 Premium Schedule

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..

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

Discounts Per Limits of Liability

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

Installments - Deferred Payments:

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

PHYSICIAN'S RATE CLASSIFICATIONS

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

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

Class 2-A
Emergency Medicine

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

Class 4
Anesthesiology

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

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

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

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

PROFESSIONAL LIABILITY COVERAGES

Explanation of Policy:

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

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

Cost:

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

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

Limits of Liability:

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

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

Tail Coverages:

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

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

Cost:

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

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

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

Retirement Benefit:

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

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

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

CLAIMS - MADE PREMIUM SCHEDULE

Effective January 1, 1989 **

LIMITS OF LIABILITY: EACH CLAIM AND ANNUAL AGGREGATE

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

ATTACHMENT E
Medical Insurance Exchange of California
1989 Premium Schedule

MIEC

Medical Insurance Exchange of California

ALASKA

1988 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
5	Assisting at Surgery
4	Cardiology*
9	Cardiovascular Surgery
8	Colon & Rectal Surgery
3	Dermatology, Excluding Hair Transplants
5	Dermatology, Including Hair Transplants
7	Dermatology—liposuction
8	Emergency Medicine
3	Endocrinology*
	Family Practice General Practice
3	— No Surgery
5	— Less than 5% of income from performance of Surgery
8	— 5% or more of income from performance of Surgery
10	— Including Obstetrics
9	— Including 5% or more income from any combination of Orthopedics, Gynecology, ENT Surgery
3	Gastroenterology*
3	General Preventive Medicine
8	General Surgery
8	Gynecology (Only)
8	Hand Surgery
8	Head & Neck Surgery
3	Hematology*
6	Industrial Medicine
3	Infectious Diseases*
3	Internal Medicine*
4	Neonatology*
3	Neoplastic Diseases*
3	Nephrology*
4	Neurology, Excluding Invasive Procedures
5	Neurology, Including Invasive Procedures
10	Neurological Surgery
3	Nuclear Medicine*
10	OB-GYN
3	Occupational Medicine (Not Industrial)
4	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
3	Pediatrics
4	Pediatric Cardiology
8	Pediatric Surgery
3	Physical Medicine and Rehabilitation
8	Plastic Surgery
1	Psychiatry**
1	Psychiatry, Child**
2	Public Health
3	Pulmonary Diseases*
7	Radiology, Diagnostic and Therapeutic
4	Radiology, Diagnostic Only*
7	Radiology, Therapeutic Only*
3	Rheumatology*
8	Thoracic Surgery, Excluding Cardiovascular
4	Urgent Care Medicine
7	Urology

*Includes all procedures, including Invasive Diagnostic Procedures, considered usual and customary to and within the training and purview of the specialty.

**Without ECT or drug shock therapy. With ECT or drug shock therapy, use Class 3.

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

Secretaries, Receptionists and Bookkeepers — No charge.

Optional Coverages:

Professional premises/limited non-owned automobile liability

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

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

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

Defense coverage for miscellaneous liability

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

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

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

PREMIUM: Individuals and solo professional corporation: $1,800 per year. Individuals with more than 10 employees, medical corporations with more than one physician shareholder, partnerships, laboratories and all other non-individual policyholders should contact MIEC for a special application and premium quotation.

MIEC **Medical Insurance Exchange of California**

ALASKA

Claims Made Professional Liability Premium Schedule

Effective June 1, 1988

Limits of Liability: 500,000 Each Claim / 1,500,000 Annual Aggregate

DOCTORS COVERAGE CLASSIFICATIONS	FIRST YEAR RATES RETROACTIVE DATES: 01/01/88 OR LATER		SECOND YEAR RATES RETROACTIVE DATES: 01/01/87 - 12/31/87		THIRD YEAR RATES RETROACTIVE DATES: 01/01/86 - 12/31/86		FOURTH YEAR RATES RETROACTIVE DATES: 01/01/85 - 12/31/85		FIFTH YEAR RATES RETROACTIVE DATES: 08/01/75 - 12/31/84	
	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY
1. COVERAGE CLASS 1	1,900	475	3,732	933	4,744	1,186	5,120	1,280	5,564	1,391
2. COVERAGE CLASS 2	2,416	604	4,748	1,187	6,036	1,509	6,516	1,629	7,080	1,770
3. COVERAGE CLASS 3	3,448	862	6,784	1,696	8,620	2,155	9,312	2,328	10,116	2,529
4. COVERAGE CLASS 4	3,968	992	7,800	1,950	9,912	2,478	10,708	2,677	11,632	2,908
5. COVERAGE CLASS 5	6,036	1,509	11,868	2,967	15,084	3,771	16,292	4,073	17,700	4,425
6. COVERAGE CLASS 6	6,724	1,681	13,224	3,306	16,808	4,202	18,152	4,538	19,724	4,931
7. COVERAGE CLASS 7	8,620	2,155	16,952	4,238	21,548	5,387	23,272	5,818	25,284	6,321
8. COVERAGE CLASS 8	12,412	3,103	24,412	6,103	31,032	7,758	33,512	8,378	36,408	9,102
9. COVERAGE CLASS 9	17,240	4,310	33,904	8,476	43,096	10,774	46,544	11,636	50,568	12,642
10. COVERAGE CLASS 10	23,444	5,861	46,108	11,527	58,612	14,653	63,300	15,825	68,772	17,193
11. NURSE/TECHNICIAN	148	37	288	72	364	91	392	98	428	107
12 PHYSIOTHERAPIST	292	73	572	143	728	182	784	196	852	213
13. PHYS ASST/NURSE PRAC	348	87	680	170	864	216	932	233	1,012	253

The Retroactive Date is the original date of your first MIEC policy.

6250 Claremont Avenue, Oakland, California 94618-1324
Telephone (415) 428-9411 / From outside California (800) 227-4527

MIEC **Medical Insurance Exchange of California**

ALASKA

Claims Made Professional Liability Premium Schedule

Effective June 1, 1988

Limits of Liability: 1,000,000 Each Claim / 3,000,000 Annual Aggregate

DOCTORS COVERAGE CLASSIFICATIONS	FIRST YEAR RATES RETROACTIVE DATES: 01/01/88 OR LATER		SECOND YEAR RATES RETROACTIVE DATES: 01/01/87 - 12/31/87		THIRD YEAR RATES RETROACTIVE DATES: 01/01/86 - 12/31/86		FOURTH YEAR RATES RETROACTIVE DATES: 01/01/85 - 12/31/85		FIFTH YEAR RATES RETROACTIVE DATES: 08/01/75 - 12/31/84	
	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY
1. COVERAGE CLASS 1	2,232	558	4,388	1,097	5,580	1,395	6,024	1,506	6,544	1,636
2. COVERAGE CLASS 2	2,840	710	5,584	1,396	7,100	1,775	7,668	1,917	8,332	2,083
3. COVERAGE CLASS 3	4,060	1,015	7,980	1,995	10,144	2,536	10,952	2,738	11,900	2,975
4. COVERAGE CLASS 4	4,668	1,167	9,176	2,294	11,664	2,916	12,596	3,149	13,684	3,421
5. COVERAGE CLASS 5	7,100	1,775	13,960	3,490	17,748	4,437	19,168	4,792	20,824	5,206
6. COVERAGE CLASS 6	7,912	1,978	15,556	3,889	19,776	4,944	21,356	5,339	23,204	5,801
7. COVERAGE CLASS 7	10,144	2,536	19,944	4,986	25,352	6,338	27,380	6,845	29,748	7,437
8. COVERAGE CLASS 8	14,604	3,651	28,720	7,180	36,508	9,127	39,428	9,857	42,832	10,708
9. COVERAGE CLASS 9	20,284	5,071	39,888	9,972	50,704	12,676	54,760	13,690	59,492	14,873
10. COVERAGE CLASS 10	27,584	6,896	54,244	13,561	68,956	17,239	74,472	18,618	80,904	20,226
11. NURSE/TECHNICIAN	172	43	336	84	428	107	464	116	500	125
12. PHYSIOTHERAPIST	344	86	672	168	856	214	924	231	1,000	250
13. PHYS ASST/NURSE PRAC	408	102	800	200	1,016	254	1,096	274	1,192	298

The Retroactive Date is the original date of your first MIEC policy.

6250 Claremont Avenue, Oakland, California 94618-1324
Telephone (415) 428-9411 / From outside California (800) 227-4527

MIEC **Medical Insurance Exchange of California**

ALASKA

Claims Made Professional Liability Premium Schedule

Effective June 1, 1988

Limits of Liability: 2,000,000 Each Claim / 4,000,000 Annual Aggregate

DOCTORS COVERAGE CLASSIFICATIONS	FIRST YEAR RATES RETROACTIVE DATES: 01/01/88 OR LATER		SECOND YEAR RATES RETROACTIVE DATES: 01/01/87 - 12/31/87		THIRD YEAR RATES RETROACTIVE DATES: 01/01/86 - 12/31/86		FOURTH YEAR RATES RETROACTIVE DATES: 01/01/85 - 12/31/85		FIFTH YEAR RATES RETROACTIVE DATES: 08/01/75 - 12/31/84	
	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY
1. COVERAGE CLASS 1	2,968	742	5,836	1,459	7,420	1,855	8,012	2,003	8,704	2,176
2. COVERAGE CLASS 2	3,408	852	6,704	1,676	8,520	2,130	9,200	2,300	9,996	2,499
3. COVERAGE CLASS 3	4,868	1,217	9,576	2,394	12,168	3,042	13,144	3,286	14,280	3,570
4. COVERAGE CLASS 4	5,600	1,400	11,008	2,752	13,996	3,499	15,116	3,779	16,420	4,105
5. COVERAGE CLASS 5	8,520	2,130	16,752	4,188	21,296	5,324	23,000	5,750	24,988	6,247
6. COVERAGE CLASS 6	9,492	2,373	18,668	4,667	23,728	5,932	25,620	6,407	27,844	6,961
7. COVERAGE CLASS 7	12,676	3,169	24,928	6,232	31,688	7,922	34,224	8,556	37,184	9,296
8. COVERAGE CLASS 8	18,252	4,563	35,896	8,974	45,632	11,408	49,284	12,321	53,540	13,385
9. COVERAGE CLASS 9	26,364	6,591	51,852	12,963	65,912	16,478	71,184	17,796	77,336	19,334
10. COVERAGE CLASS 10	36,960	9,240	72,688	18,172	92,396	23,099	99,788	24,947	108,412	27,103
11. NURSE/TECHNICIAN	208	52	404	101	512	128	556	139	600	150
12. PHYSIOTHERAPIST	412	103	808	202	1,024	256	1,108	277	1,200	300
13. PHYS ASST/NURSE PRAC	488	122	960	240	1,220	305	1,316	329	1,428	357

The Retroactive Date is the original date of your first MIEC policy.

6250 Claremont Avenue, Oakland, California 94618-1324
Telephone (415) 428-9411 / From outside California (800) 227-4527

MIEC **Medical Insurance Exchange of California**

ALASKA

Claims Made Professional Liability Premium Schedule

Effective June 1, 1988

Limits of Liability: 5,000,000 Each Claim / 5,000,000 Annual Aggregate

DOCTORS COVERAGE CLASSIFICATIONS	FIRST YEAR RATES RETROACTIVE DATES: 01/01/88 OR LATER		SECOND YEAR RATES RETROACTIVE DATES: 01/01/87 - 12/31/87		THIRD YEAR RATES RETROACTIVE DATES: 01/01/86 - 12/31/86		FOURTH YEAR RATES RETROACTIVE DATES: 01/01/85 - 12/31/85		FIFTH YEAR RATES RETROACTIVE DATES: 08/01/75 - 12/31/84	
	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY
1. COVERAGE CLASS 1	3,712	928	7,296	1,824	9,272	2,318	10,016	2,504	10,880	2,720
2. COVERAGE CLASS 2	4,260	1,065	8,376	2,094	10,648	2,662	11,500	2,875	12,496	3,124
3. COVERAGE CLASS 3	6,084	1,521	11,968	2,992	15,212	3,803	16,428	4,107	17,848	4,462
4. COVERAGE CLASS 4	7,000	1,750	13,760	3,440	17,492	4,373	18,892	4,723	20,524	5,131
5. COVERAGE CLASS 5	10,648	2,662	20,940	5,235	26,620	6,655	28,748	7,187	31,232	7,808
6. COVERAGE CLASS 6	11,864	2,966	23,336	5,834	29,660	7,415	32,036	8,009	34,804	8,701
7. COVERAGE CLASS 7	15,844	3,961	31,160	7,790	39,612	9,903	42,780	10,695	46,476	11,619
8. COVERAGE CLASS 8	22,816	5,704	44,872	11,218	57,040	14,260	61,604	15,401	66,924	16,731
9. COVERAGE CLASS 9	32,956	8,239	64,812	16,203	82,388	20,597	88,980	22,245	96,668	24,167
10. COVERAGE CLASS 10	46,200	11,550	90,856	22,714	115,496	28,874	124,736	31,184	135,516	33,879
11. NURSE/TECHNICIAN	256	64	504	126	640	160	692	173	752	188
12. PHYSIOTHERAPIST	512	128	1,008	252	1,280	320	1 384	346	1,500	375
13. PHYS ASST/NURSE PRAC	612	153	1,200	300	1,524	381	1,644	411	1,788	447

The Retroactive Date is the original date of your first MIEC policy.

6250 Claremont Avenue, Oakland, California 94618-1324
Telephone (415) 428-9411 / From outside California (800) 227-4527

MIEC

Medical Insurance Exchange of California

ALASKA

Claims Made Professional Liability Premium Schedule

Effective June 1, 1988

First Year New Doctor Rule Rates*

Retroactive Date 1/1/88 or Later

DOCTORS COVERAGE CLASSIFICATIONS	LIMITS 1 500,000/1,500,000		LIMITS 2 1,000,000/3,000,000		LIMITS 3 2,000,000/4,000,000		LIMITS 4 5,000,000/5,000,000	
	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY	ANNUAL	QUARTERLY
1. COVERAGE CLASS 1	475	118.75	558	139.50	742	185.50	928	232.00
2. COVERAGE CLASS 2	604	151.00	710	177.50	852	213.00	1,065	266.25
3. COVERAGE CLASS 3	862	215.50	1,015	253.75	1,217	304.25	1,521	380.25
4. COVERAGE CLASS 4	992	248.00	1,167	291.75	1,400	350.00	1,750	437.50
5. COVERAGE CLASS 5	1,509	377.25	1,775	443.75	2,130	532.50	2,662	665.50
6. COVERAGE CLASS 6	1,681	420.25	1,978	494.50	2,373	593.25	2,966	741.50
7. COVERAGE CLASS 7	2,155	538.75	2,536	634.00	3,169	792.25	3,961	990.25
8. COVERAGE CLASS 8	3,103	775.75	3,651	912.75	4,563	1,140.75	5,704	1,426.00
9. COVERAGE CLASS 9	4,310	1,077.50	5,071	1,267.75	6,591	1,647.75	8,239	2,059.75
10. COVERAGE CLASS 10	5,861	1,465.25	6,896	1,724.00	9,240	2,310.00	11,550	2,887.50

ALASKA
DATE PREPARED: MARCH 17,1988
PROCEDURE: NDPREM
USERID: MIECUWK

*These rates apply only to physicians entering the practice of medicine for the first time after completion of a residency, fellowship training or military service.

6250 Claremont Avenue, Oakland, California 94618-1324
Telephone (415) 428-9411 / From outside California (800) 227-4527

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P.O. Box Y, State Capitol
Juneau, Alaska 99811-3100
Mail Stop 3100
(907) 465-3991

April 18, 1989

MEMORANDUM

TO: Representative Peter Goll

ATTN: Hayden Kaden

FROM: Karen Oakley KO
Legislative Analyst

RE: **Medical Malpractice Premiums Paid by Alaska Doctors**
Research Request 89.297 (Supplemental Information)

You requested further information concerning medical malpractice insurance in Alaska. Specifically, you wanted to know how many private doctors are covered by the Medical Indemnity Corporation of Alaska (MICA) and how many are covered by other insurance companies or are without insurance. You also asked about reinsurance purchased by MICA.

According to Art Stanford, with the MICA underwriting department, MICA currently covers about 250 individual physicians, ten hospitals and ten to 12 "related health care facilities." The latter include clinics, such as the Alaska Kidney Center, which are staffed primarily by technicians.

There are just over 600 doctors in private practice in Alaska, thus, 40 percent of the private doctors in Alaska are insured with MICA. I was unable to obtain estimates of the number of doctors insured by each of the 22 other companies writing medical malpractice insurance in Alaska. In 1988, MICA had 48 percent of the medical malpractice market in Alaska, so these other companies together probably insure a similar number of doctors, leaving some 100 to 125 private doctors without insurance. This estimate of the number of uninsured doctors is consistent with the observations of Mary Pierce, executive director of MICA; she estimates that from 15 to 20 percent of Alaska's private doctors are currently "going bare".

Ms. Pierce provided information on reinsurance purchased by MICA. She indicated that MICA pays about $1.2 million for reinsurance annually. The primary reinsurer is Lloyd's of London, but a number of other companies, including at least one domestic hospital reinsurance company, sign on the policy. The MICA's retention (i.e., deductible portion) is $250,000 per claim, however, the retention is indexed and increases by about 10 percent per year between the time the claim is made and the time the claim is settled.

The MICA is an associate member of the Physicians' Insurance Association of America (PIAA). Because MICA is not a physician-owned company, MICA cannot be a full member of the PIAA. The MICA has broached the idea of putting together a reinsurance pool with the other members of PIAA, but the idea has not generated much interest. Compared with the other companies in the association, MICA is small, and the other companies have nothing to gain from joining with MICA. For further information on MICA's reinsurance situation, please contact Ms. Pierce at 563-3414.

I hope this information is useful. Please let me know if I can provide any further information.

THE FOLLOWING DOCUMENT HAS

NOT BEEN FILMED BUT IS

AVAILABLE IN THE ORIGINAL

FILE

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

P.O. Box Y, State Capitol
Juneau, Alaska 99811-3100
Mail Stop 3100
(907) 465-3991

November 7, 1988

MEMORANDUM

TO:

ATTN:

FROM: Patricia Young
Legislative Analyst

RE: **Virginia Birth-Related Neurological Injury Compensation Act**
Research Request 89.077

You asked for information about the Virginia Birth-Related Neurological Injury Compensation Act. According to Representative Clifton Woodrum, bill sponsor, this legislation was proposed in response to the refusal of one of three major insurance carriers to provide liability insurance for physicians of obstetrics and gynecology (OB/GYN) practicing in Virginia in groups of fewer than ten.

Currently, there is a lively debate in many states, including Alaska, over whether the "insurance crisis" is genuine or a fabrication on the part of the insurance industry. Virginia's "Bad Baby Act," effective January, 1988, is one state's response to one aspect of the liability insurance crisis (see attached). This approach modifies many years of judicial experience and case law. Proponents and opponents alike will be watching this situation due to its potential impact. Several years may pass before a sufficient number of cases have been processed to determine whether or not such legislation is justified.

Virginia's act limits the liability of physicians and hospitals for birth-related neurological injuries caused or aggravated by substandard care unless there is clear and convincing evidence that injuries were intentional or willfully caused.[1] This statute effects several changes in well-established, judicially created rules for determining civil liability and damages:

---

[1]It is important to note that this statute covers only the most disabling and costly injuries. "Neurological injuries" are defined as injuries to the brain or spinal cord which render infants "permanently nonambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living" (Code of Virginia, 38.2-5001).

- The law places a statutory upper limit on the amount of damages an injured party can recover for acts of negligence, gross negligence, and recklessness.

- An injured party is allowed only a nonjudicial remedy for acts of negligence, gross negligence, and recklessness. The injured party is prohibited from seeking redress in the courts unless there is willful or intentional wrongdoing on the part of the physician and/or the hospital.

- "Preponderance of evidence" is the standard of proof generally required in civil liability cases; this law increases the standard of proof to "clear and convincing evidence," a standard generally reserved for cases with overriding public policy implications.

In the event of a birth-related neurological injury, the act provides that the Industrial Commission of Virginia will award compensation to the legal representative of the infant for the following items:

- actual medically necessary and reasonable expenses of medical and hospital, rehabilitative, residential and custodial care and service, special equipment or facilities, and related travel for which the infant has not received nor is entitled to receive reimbursement from some other source [38.2-5009 (1)];

- loss of earnings from the age of eighteen through the age of sixty-five, in the amount of fifty percent of the average weekly wage in the Commonwealth of workers in the private, nonfarm sector [38.2-5009 (3)]; and

- reasonable expenses incurred in connection with the filing of the claim, including reasonable attorneys' fees [38.2-5009 (4)].

The act stipulates that compensation is to be awarded from a fund governed by a governor-appointed board of directors and maintained by annual assessments of $5,000 from each participating OB/GYN physician; up to $150,000 from each participating hospital (based on $50 per delivery for the year prior to participation, but not to exceed $150,000 per hospital in any one twelve-month period); and $250 from each nonparticipating physician licensed by, and practicing in, the Commonwealth. According to the statute, "if required to maintain the fund on an actuarially sound basis," liability insurance carriers will also contribute annual assessments not to exceed "one quarter of one percent of . . . net direct [liability] premiums written" [38.2-5020 (B)]. Carriers are entitled to recover their assessed costs through surcharges on future policies and/or rate increases. Physicians and hospitals will presumably pass on their assessed costs to patients.

How compensation will be awarded is unclear and open to debate, and regulations implementing the statute have not been drafted. Some covered medical, rehabilitative, custodial, and equipment expenses would continue for the life of the injured, and actual costs for these expenses will vary over time. According to Representative Woodrum, the legal representative of the injured child would be required to petition the commission each year for out of pocket expenses; however, language in the statute suggests a lump sum award. Loss of earnings would occur 18 through 65 years in the future, and there appears to be disagreement regarding this award also. Representative Woodrum indicated that compensation for loss of earnings would not begin until the injured child had reached the age of eighteen and would continue only during the life of the injured. However, according to Larry Tarr, chief deputy commissioner, Virginia Industrial Commission, the award for loss of earnings would be a lump sum amount based on current wage averages.[2]

Since its proposal, the statute has been controversial: many physicians object to subsidization of OB/GYN practitioners; many consumers argue that this statute allows doctors and hospitals, under certain circumstances, to act in a negligent or reckless manner without fully compensating victims. The likely net effect of the law will be that no suits are brought against physicians or hospitals for birth-related neurological injuries. Controversy will continue, however, and law suits may arise over the current lack of administrative clarity. Steve Kaufmann, Virginia Division of Insurance, anticipates a move to repeal this statute. He also expects that the law may be challenged and, if necessary, appealed to the State Supreme Court.

I hope this information is useful to you. If you have questions, please call.

Attachment

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[2]Bob Griffin, chief economist, Virginia Employment Commission, Bureau of Labor Statistics, indicated that $371 was the 1987 average weekly wage of workers in the private, nonfarm sector. Based on the current average wage, a lump sum compensation for loss of earnings between the ages of 18 and 65 would be $463,008. If wage inflation were calculated, this amount would be substantially higher.

CODE OF VIRGINIA

1950

1988 Cumulative Supplement

ANNOTATED

Prepared under the Supervision of

The Virginia Code Commission

BY

The Editorial Staff of the Publishers

Under the Direction of

A. D. KOWALSKY, S. C. WILLARD, W. L. JACKSON,
P. R. ROANE, K. S. MAWYER, AND T. R. TROXELL

VOLUME 6A

1986 REPLACEMENT

Annotated through South Eastern Reporter, 2d Series, through Volume 364, page 832. For complete scope of annotations, see preface in supplement to Volume 1.

Place in Pocket of Corresponding Volume of Main Set. This Supersedes Previous Supplement, Which May Be Retained for Reference Purposes.

THE MICHIE COMPANY
Law Publishers
CHARLOTTESVILLE, VIRGINIA

CHAPTER 50.

VIRGINIA BIRTH-RELATED NEUROLOGICAL INJURY COMPENSATION ACT.

§ 38.2-5000. Short title. — The provisions of this chapter shall be known and may be cited as the Virginia Birth-Related Neurological Injury Compensation Act. (1987, c. 540.)

§ 38.2-5001. Definitions. — As used in this chapter:

"Birth-related neurological injury" means injury to the brain or spinal cord of an infant caused by the deprivation of oxygen or mechanical injury occurring in the course of labor, delivery or resuscitation in the immediate post-delivery period in a hospital which renders the infant permanently nonambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living. This definition shall apply to live births only.

"Claimant" means any person who files a claim pursuant to § 38.2-5004 for compensation for a birth-related neurological injury to an infant. Such claims may be filed by any legal representative on behalf of an injured infant; and, in the case of a deceased infant, the claim may be filed by an administrator, executor, or other legal representative.

"Commission" means the Industrial Commission of Virginia.

"Participating physician" means a physician licensed in Virginia to practice medicine, who practices obstetrics or performs obstetrical services either full or part time and who at the time of the injury (i) had in force an agreement with the Commissioner of Health or his designee, in a form prescribed by the Commissioner, whereby the physician agreed to participate in the development of a program to provide obstetrical care to patients eligible for Medical Assistance Services and to patients who are indigent, and upon approval of such program by the Commissioner of Health, to participate in its implementation, (ii) had in force an agreement with the State Board of Medicine whereby the physician agreed to submit to review by the Board of Medicine as required by subsection B of § 38.2-5004, and (iii) had paid the assessment required pursuant to this chapter for the year in which the injury occurred.

"Participating hospital" means a hospital licensed in Virginia which at the time of the injury (i) had in force an agreement with the Commissioner of

Health or his designee, in a form prescribed by the Commissioner, whereby the hospital agreed to participate in the development of a program to provide obstetrical care to patients eligible for Medical Assistance Services and to patients who are indigent, and upon approval of such program by the Commissioner of Health, to participate in its implementation, (ii) had in force an agreement with the State Department of Health whereby the hospital agreed to submit to review of its obstetrical service, as required by subsection C of § 38.2-5004, and (iii) had paid the assessment required pursuant to this chapter for the year in which the injury occurred.

"*Program*" means the Virginia Birth-Related Neurological Injury Compensation Program established by this chapter. (1987, c. 540.)

§ 38.2-5002. Virginia Birth-Related Neurological Injury Compensation Program; exclusive remedy; exception. — A. There is hereby established the Virginia Birth-Related Neurological Injury Compensation Program.

B. The rights and remedies herein granted to an infant on account of a birth-related neurological injury shall exclude all other rights and remedies of such infant, his personal representative, parents, dependents or next of kin at common law or otherwise arising out of or related to a medical malpractice claim with respect to such injury.

C. Notwithstanding anything to the contrary in this section, a civil action shall not be foreclosed against a physician or a hospital where there is clear and convincing evidence that such physician or hospital intentionally or willfully caused or intended to cause a birth-related neurological injury, provided that such suit is filed prior to and in lieu of payment of an award under this chapter. Such suit shall be filed before the award of the Commission becomes conclusive and binding as provided for in § 38.2-5011. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5003. Industrial Commission authorized to hear and determine claims. — The Industrial Commission is authorized to hear and pass upon all claims filed pursuant to this chapter. The Commission may exercise the power and authority granted to it in Chapter 2 (§ 65.1-10 et seq.) of Title 65.1 as necessary to carry out the purposes of this chapter. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5004. Filing of claims; review by Board of Medicine; review by Department of Health; filing of reponses. — A. 1. In all claims filed under this chapter, the claimant shall file with the Commission a petition, setting forth the following information:

a. The name and address of the legal representative and the basis for his representation of the injured infant;

b. The name and address of the injured infant;

c. The name and address of any physician providing obstetrical services who was present at the birth and the name and address of the hospital at which the birth occurred;

d. A description of the disability for which claim is made;

e. The time and place where the injury occurred;

f. A brief statement of the facts and circumstances surrounding the injury and giving rise to the claim;

g. All available relevant medical records relating to the person who allegedly suffered a birth-related neurological injury and an identification of any unavailable records known to the claimant and the reasons for their unavailability;

h. Appropriate assessments, evaluations, and prognoses and such other records and documents as are reasonably necessary for the determination of the amount of compensation to be paid to, or on behalf of, the injured infant on account of a birth-related neurological injury;

i. Documentation of expenses and services incurred to date, which indicates whether such expenses and services have been paid for, and if so, by whom; and

j. Documentation of any applicable private or governmental source of services or reimbursement relative to the alleged impairments.

2. The claimant shall furnish the Commission with as many copies of the petition as required for service upon the Program, any physician and hospital named in the petition, the Board of Medicine and the Department of Health, along with a fifteen dollar filing fee. Upon receipt of the petition the Commission shall immediately serve the Program by service upon the agent designated to accept service on behalf of the Program in the plan of operation by registered or certified mail, and shall mail copies of the petition to any physician and hospital named in the petition, the Board of Medicine and the Department of Health.

B. Upon receipt of the petition, the Board of Medicine shall evaluate the claim, and if it determines that there is reason to believe that the alleged injury resulted from, or was aggravated by, substandard care on the part of the physician, it shall take any appropriate action consistent with the authority granted to the Board in §§ 54-316 through 54-325.

C. Upon receipt of the petition, the Department of Health shall evaluate the claim, and if it determines that there is reason to believe that the alleged injury resulted from, or was aggravated by, substandard care on the part of the hospital at which the birth occurred, it shall take any appropriate action consistent with the authority granted to the Department of Health in Title 32.1.

D. The Program shall have thirty days from the date of service in which to file a response to the petition, and to submit relevant written information relating to the issue of whether the injury alleged is a birth-related neurological injury, within the meaning of this chapter. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5005. Tolling of statute of limitations. — The statute of limitations with respect to any civil action that may be brought by or on behalf of an injured infant allegedly arising out of or related to a birth-related injury shall be tolled by the filing of a claim in accordance with this section, and the time such claim is pending shall not be computed as part of the period within which such civil action may be brought. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5006. Hearing; parties. — A. Immediately after such petition has been received, the Commission shall set the date for a hearing, which shall be held no sooner than 45 days and no later than 120 days after the filing of a petition, and shall notify the parties thereto of the time and place of such hearing. The hearing shall be held in the city or county where the injury

occurred, or in a contiguous city or county, unless otherwise agreed to by the parties and authorized by the Commission.

B. The parties to the hearing required under this section shall include the claimant and the Program. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5007. Interrogatories and depositions. — Any party to a proceeding under this chapter may, upon application to the Commission setting forth the materiality of the evidence to be given, serve interrogatories or cause the depositions of witnesses residing within or without the Commonwealth to be taken, the costs to be taxed as expenses incurred in connection with the filing of a claim, in accordance with subdivision 2 of § 38.2-5009. Such depositions shall be taken after giving notice and in the manner prescribed by law, for depositions in actions at law, except that they shall be directed to the Commission, the Commissioner or the Deputy Commissioner before whom the proceedings may be pending. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5008. Determination of claims; presumption; finding of Industrial Commission binding on participants; medical advisory panel. — A. The Commission shall determine, on the basis of the evidence presented to it, the following issues:

1. Whether the injuries claimed are birth-related neurological injuries as defined in § 38.2-5001. A rebuttable presumption shall arise that the injury alleged is a birth-related neurological injury where it has been demonstrated, to the satisfaction of the Industrial Commission, that the infant has sustained a brain or spinal cord injury caused by oxygen deprivation or mechanical injury, and that the infant was thereby rendered permanently nonambulatory, aphasic and incontinent.

If either party disagrees with such presumption, that party shall have the burden of proving that the injuries alleged are not birth-related neurological injuries within the meaning of the chapter.

2. Whether obstetrical services were delivered by a participating physician at the birth.

3. Whether the birth occurred in a participating hospital.

4. How much compensation, if any, is awardable pursuant to § 38.2-5009.

5. If the Commission determines (i) that the injury alleged is not a birth-related neurological injury within the meaning of this chapter, (ii) that obstetrical services were not delivered by a participating physician at the birth, or (iii) that the birth did not occur in a participating hospital, it shall cause a copy of such determination to be sent immediately to the parties by registered or certified mail.

6. By becoming a participating physician or hospital each participant is bound for all purposes including any suit at law against a participating physician or participating hospital, by the finding of the Industrial Commission (or any appeal therefrom) with respect to whether such injury is birth-related.

B. The deans of the medical schools of the Commonwealth shall develop a plan whereby each claim filed with the Commission is reviewed by a panel of three qualified and impartial physicians. This panel shall file its report and recommendations as to whether the injury alleged is a birth-related neurological injury within the meaning of this chapter with the Commission at least

ten days prior to the date set for hearing pursuant to § 38.2-5006. At the request of the Commission, at least one member of the panel shall be available to testify at the hearing. The Commission must consider, but shall not be bound by, the recommendation of the panel. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5009. Commission awards for birth-related neurological injuries; notice of award. — Upon determining (i) that an infant has sustained a birth-related neurological injury, (ii) that obstetrical services were delivered by a participating physician at the birth, and (iii) that the birth occurred in a participating hospital, the Commission shall make an award providing compensation for the following items relative to such injury:

1. Actual medically necessary and reasonable expenses of medical and hospital, rehabilitative, residential and custodial care and service, special equipment or facilities, and related travel. However, such expenses shall not include:

a. Expenses for items or services that the infant has received, or is entitled to receive, under the laws of any state or the federal government except to the extent prohibited by federal law;

b. Expenses for items or services that the infant has received, or is contractually entitled to receive, from any prepaid health plan, health maintenance organization, or other private insuring entity;

c. Expenses for which the infant has received reimbursement, or for which the infant is entitled to receive reimbursement, under the laws of any state or federal government except to the extent prohibited by federal law; and

d. Expenses for which the infant has received reimbursement, or for which the infant is contractually entitled to receive reimbursement, pursuant to the provisions of any health or sickness insurance policy or other private insurance program.

2. Expenses of medical and hospital services under subdivision 1 of this section shall be limited to such charges as prevail in the same community for similar treatment of injured persons of a like standard of living when such treatment is paid for by the injured person.

3. Loss of earnings from the age of eighteen. — An infant found to have sustained a birth-related neurological injury shall be conclusively presumed to have been able to earn income from work from the age of eighteen through the age of sixty-five, if he had not been injured, in the amount of fifty percent of the average weekly wage in the Commonwealth of workers in the private, nonfarm sector.

4. Reasonable expenses incurred in connection with the filing of a claim under this chapter, including reasonable attorneys' fees, which shall be subject to the approval and award of the Commission.

5. A copy of the award shall be sent immediately by registered or certified mail to the parties. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5010. Rehearing on Commission determination or award. — If an application for review is made to the Commission within twenty days from the date of a determination pursuant to subdivisions A 1 through A 3 of § 38.2-5008, or within twenty days from the date of an award by the Commission pursuant to § 38.2-5009, the full Commission, excluding any member of the Commission who made the determination or award, if the first

hearing was not held before the full Commission, shall review the evidence. If deemed advisable and as soon as practicable, the Commission instead may hear the parties, their representatives and witnesses and shall make a determination or award, as appropriate. Such review or determination, together with a statement of the findings of fact, rulings of law and other matters pertinent to the questions at issue, shall be filed with the record of the proceedings and shall be sent immediately to the parties. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5011. Conclusiveness of determination or award; appeal. — A. The determination of the Commission pursuant to subdivisions A 1 through A 3 of § 38.2-5008, or the award of the Commission, as provided in § 38.2-5009, if not reviewed in due time, or a determination or award of the Commission upon such review, as provided in § 38.2-5010, shall be conclusive and binding as to all questions of fact. No appeal shall be taken from the decision of one commissioner until a review of the case has been had before the full Commission, as provided in § 38.2-5010. Appeals shall lie from the full Commission to the Court of Appeals in the manner provided in the Rules of the Supreme Court.

B. The notice of appeal shall be filed with the clerk of the Commission within thirty days from the date of such determination or award or within thirty days after receipt by registered or certified mail of such determination or award. A copy of the notice of appeal shall be filed in the office of the clerk of the Court of Appeals as provided in the Rules of the Supreme Court.

C. Cases so appealed shall be placed upon the privileged docket of the Court and be heard at the next ensuing term thereof. In case of an appeal from an award of the Commission to the Court of Appeals, the appeal shall operate as a suspension of the award, and the Program shall not be required to make payment of the award involved in the appeal until the questions at issue therein shall have been fully determined in accordance with the provisions of this chapter. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5012. Enforcement, etc., of orders and awards. — The Commission has full authority to enforce its orders and protect itself from deception. While the language of this section is permissive and provides that a party may enforce an award in court, it must be read and considered in pari materia with the Commission's power pursuant to § 65.1-20 to punish for disobedience of its orders. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5013. Limitation on claims. — Any claim under this chapter that is filed more than ten years after the birth of an infant alleged to have a birth-related neurological injury is barred. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5014. Scope. — This chapter applies to all claims for birth-related neurological injuries occurring in this Commonwealth on and after January 1, 1988. The chapter shall not apply to disability or death caused by genetic or congenital abnormalities. (1987, c. 540.)

Effective date. — This section became effective Jan. 1, 1988.

§ 38.2-5015. Birth-Related Neurological Injury Compensation Fund. — There is established the Birth-Related Neurological Injury Compensation Fund to finance the Virginia Birth-Related Neurological Injury Compensation Program created by this chapter. (1987, c. 540.)

§ 38.2-5016. Board of directors; appointment; vacancies; term. — A. The Birth-Related Neurological Injury Compensation Program shall be governed by a board of five directors.

B. Directors shall be appointed for a term of three years or until their successors are appointed and have qualified.

C. 1. The directors shall be appointed by the Governor as follows:

a. One citizen representative;

b. One representative of participating physicians;

c. One representative of participating hospitals;

d. One representative of liability insurers; and

e. One representative of physicians other than participating physicians.

2. The Governor may select the representative of the participating physicians from a list of at least three names to be recommended by the Virginia Society of Obstetrics and Gynecology; the representative of participating hospitals from a list of at least three names to be recommended by the Virginia Hospital Association; the representative of liability insurers from a list of at least three names, one of which is recommended by the American Insurance Association, one by the Alliance of American Insurers, and one by the National Association of Independent Insurers; and the representative of physicians other than participating physicians from a list of at least three names to be recommended by the Medical Society of Virginia. In no case shall the Governor be bound to make any appointment from among the nominees of the respective associations.

D. The Governor shall promptly notify the association, which may make nominations, of any vacancy other than by expiration among the members of the board representing a particular interest and like nominations may be made for the filling of the vacancy.

E. The directors shall act by majority vote with five directors constituting a quorum for the transaction of any business or the exercise of any power of the Program. The directors shall serve without salary, but each director shall be reimbursed for actual and necessary expenses incurred in the performance of his official duties as a director of the Program. The directors shall not be subject to any personal liability with respect to the administration of the Program.

F. The board established by this section shall have the power to (i) administer the Program, (ii) administer the Birth-Related Neurological Injury Compensation Fund, (iii) appoint a service company or companies to administer the payment of claims on behalf of the Program, (iv) direct the investment and reinvestment of any surplus in the Fund over losses and expenses, provided any investment income generated thereby remains in the Fund, and (v) reinsure the risks of the Fund in whole or in part. (1987, c. 540.)

§ 38.2-5017. Plan of operation. — A. On or before September 30, 1987, the directors of the Program shall submit to the State Corporation Commission for review a proposed plan of operation consistent with this chapter.

B. The plan of operation shall provide for the efficient administration of the Program and for the prompt processing of claims made against the Fund pursuant to an award under this chapter. The plan shall contain other provisions including:

1. Establishment of necessary facilities;

2. Management of the Fund;

3. Appointment of servicing carriers or other servicing arrangements to administer the processing of claims against the Fund;

4. Initial and annual assessment of the persons and entities listed in § 38.2-5019 to pay awards and expenses, which assessments shall be on an actuarially sound basis subject to the limits set forth in § 38.2-5019; and

5. Any other matters necessary for the efficient operation of the Program.

C. The plan of operation shall be subject to approval by the State Corporation Commission after consultation with representatives of interested individuals and organizations. If the State Corporation Commission disapproves all or any part of the proposed plan of operation, the directors shall within thirty days submit for review an appropriate revised plan of operation. If the directors fail to do so, the State Corporation Commission shall promulgate a plan of operation. The plan of operation approved or promulgated by the State Corporation Commission shall become effective and operational upon order of the State Corporation Commission.

D. Amendments to the plan of operation may be made by the directors of the Program, subject to the approval of the State Corporation Commission. (1987, c. 540.)

§ 38.2-5018. Assessments to be held in restricted cash account. — All assessments paid pursuant to the plan of operation, shall be held in a separate restricted cash account under the sole control of an independent fund manager to be selected by the directors. The Fund, and any income from it, shall be disbursed for the payment of awards as provided in this chapter and for the payment of the expenses of administration of the Fund. (1987, c. 540.)

§ 38.2-5019. Initial assessments. — A. On or before January 1, 1988, the following persons and entities shall pay into the Fund an initial assessment in accordance with the plan of operation:

1. Physicians who wish to participate in the Virginia Birth-Related Neurological Injury Compensation Program and who otherwise qualify as participating physicians under this chapter shall pay an initial assessment of $5,000.

Any physician who is otherwise eligible to become a participating physician, but who did not meet the requirements of § 38.2-5001 on or before January 1, 1988, may become a participating physician by filing the agreements required by § 38.2-5001 and by paying an assessment to the Program on or before May 15, 1988. The amount of this assessment shall be determined by the Board of Directors of the Program on a prorated basis for the months remaining in 1988 at the time the assessment is paid. A physician who satisfies the conditions imposed by this paragraph shall be considered a participating physician in the Program for the remainder of 1988, beginning on the first day of the first month following the receipt by the Program of the required agreements and prorated assessment.

Physicians who are employed by the Commonwealth who wish to participate in the Program and who otherwise qualify as participating physicians may pay the assessment required by this subsection on or before July 31,

1988, provided they have notified the Program on or before January 1, 1988, of their desire to participate in the Program. Such participation shall become effective retroactive to January 1, 1988, at the time the assessment is received by the Program.

2. Hospitals which wish to participate in the Virginia Birth-Related Neurological Injury Program and that otherwise qualify as participating hospitals under this chapter shall pay an initial assessment of $50 per delivery for the prior year, as reported to the Department of Health in the most recent annual licensure survey of hospitals, not to exceed $150,000 per hospital in any one twelve-month period.

Any hospital which is otherwise eligible to become a participating hospital, but which did not meet the requirements of § 38.2-5001 on or before January 1, 1988, may become a participating hospital by filing the agreements required by § 38.2-5001 and by paying an assessment to the Program on or before May 15, 1988. The amount of the assessment shall be determined by the Board of Directors of the Program on a prorated basis for the months remaining in 1988 at the time the assessment is paid. A hospital satisfying the conditions imposed by this paragraph shall be considered a participating hospital in the Program for the remainder of 1988, beginning on the first day of the first month following the receipt by the Program of the required agreements and prorated assessment.

State hospitals which wish to participate in the Program and which otherwise qualify as participating hospitals may pay the assessment required by this subsection on or before July 31, 1988, provided they have notified the Program on or before January 1, 1988, of their desire to participate. Such participation shall become effective retroactive to January 1, 1988, at the time the assessment is received by the Program.

3. All physicians licensed by and practicing in the Commonwealth as of September 30, 1987, other than participating physicians, shall pay into the Fund an initial assessment of $250, in the manner required by the plan of operation.

B. Upon so certifying to the Program, any physician who comes within one of the following categories shall be exempt from paying the initial and annual assessments imposed upon physicians other than participating physicians pursuant to this chapter:

1. A physician who is employed by the Commonwealth and whose income from professional fees is less than an amount equal to ten percent of his annual salary.

2. A physician who is enrolled in a full-time graduate medical education program accredited by the American Council for Graduate Medical Education.

3. A physician who has retired from active clinical practice. (1987, c. 540; 1988, c. 164.)

The 1988 amendment, effective March 20, 1988, added the second paragraph of subdivision A 1 and added the second paragraph of subdivision A 2.

§ 38.2-5020. Annual assessments. — A. Beginning January 1, 1989, the persons and entities listed in subdivisions 1 through 3 of subsection A of § 38.2-5019, as of the date determined in accordance with the plan of operation, shall pay an annual assessment in the amount equal to their initial asssessments, in the manner required by the plan of operation.

B. Taking into account the assessments collected pursuant to subsection A of this section, if required to maintain the Fund on an actuarially sound basis, all insurance carriers licensed to write and engaged in writing liability insurance in the Commonwealth as of September 30, 1988, shall pay into the Fund an annual assessment, in an amount determined by the State

Corporation Commission pursuant to subsection A of § 38.2-5021, in the manner required by the plan of operation. Liability insurance for the purposes of this provision shall include the classes of insurance defined in §§ 38.2-117 through 38.2-119 and the liability portions of the insurance defined in §§ 38.2-124, 38.2-125 and 38.2-130 through 38.2-132.

1. All annual assessments against liability insurance carriers shall be made on the basis of net direct premiums written for the business activity which forms the basis for each such entity's inclusion as a funding source for the Program in the Commonwealth during the prior year ending December 31, as reported to the State Corporation Commission, and shall be in the proportion that the net direct premiums written by each on account of the business activity forming the basis for their inclusion in the Program bears to the aggregate net direct premiums for all such business activity written in this Commonwealth by all such entities. For purposes of this chapter "net direct premiums written" means gross direct premiums written in this Commonwealth on all policies of liability insurance less (i) all return premiums on the policy, (ii) dividends paid or credited to policyholders, and (iii) the unused or unabsorbed portions of premium deposits on liability insurance.

2. The entities listed in this subsection shall not be individually liable for an annual assessment in excess of one quarter of one percent of that entity's net direct premiums written.

3. Liability insurance carriers shall be entitled to recover their initial and annual assessments through (i) a surcharge on future policies, (ii) a rate increase applicable prospectively, or (iii) a combination of the two, at the discretion of the State Corporation Commission. (1987, c. 540.)

§ 38.2-5021. Actuarial investigation, valuations, gain/loss analysis; notice if assessments prove insufficient. — A. The Bureau of Insurance of the State Corporation Commission shall undertake an actuarial investigation of the requirements of the Fund based on the Fund's experience in the first year of operation, including without limitation the assets and liabilities of the Fund. Pursuant to such investigation, the State Corporation Commission shall establish the rate of contribution of the entities listed in subsection B of § 38.2-5020 for the tax year beginning January 1, 1989.

Following the initial valuation, the State Corporation Commission shall cause an actuarial valuation to be made of the assets and liabilities of the Fund no less frequently than biennially. Pursuant to the results of such valuations, the State Corporation Commission shall prepare a statement as to the contribution rate applicable to contributors listed in subsection B of § 38.2-5020. However, at no time shall the rate be greater than one quarter of one percent of net direct premiums written.

B. In the event that the State Corporation Commission finds that the Fund cannot be maintained on an actuarially sound basis subject to the maximum assessments listed in §§ 38.2-5019 and 38.2-5020, the Commission shall promptly notify the Speaker of the House of Delegates, the President of the Senate, and the Industrial Commission. (1987, c. 540.)

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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February 14, 1989

MEMORANDUM

TO:

ATTN:

FROM: Patricia Young PY
Legislative Analyst

RE: **Virginia Birth-Related Neurological Injury Compensation Act**
Research Request 89.077 (Supplemental Information)

After receiving the memorandum describing the Virginia Birth-Related Neurological Injury Compensation Act, you asked for information on changes in insurance premium rates for physicians and consumers resulting from passage of the act. You also requested information on solutions proposed by other states for dealing with this aspect of liability insurance. In addition, you asked for comments on whether or not a similar act would improve the liability insurance situation in Alaska.

Virginia's Birth-Related Neurological Injury Compensation Act--Results

Since the Virginia statute's effective date of January 1, 1988, no claims for compensation have been made. According to Bob Miller, deputy commissioner of regulation, Virginia Division of Insurance, passage of the act has resulted in a premium discount of approximately ten percent for participating obstetricians. If removing catastrophically damaged children from the tort system reduces costs, then premiums will probably decrease more significantly. Such decreases would not occur immediately, however, because insurers are still responsible for babies injured prior to the effective date. Furthermore, whether or not costs will be reduced is uncertain. The Virginia Legislature estimated that 40 children per year would meet the criteria for compensation. An actuarial firm estimated the cost per child at $500,000. Based on the estimate of 40 children, projected revenues of $14 million would fall short of the $20 million in costs. The shortfall could be far greater, however, because the actuarial analysis did not take into account the loss of earnings provision.

According to Ken Heland, associate director of the American College of Obstetricians and Gynecologists and head of the Department of Professional Liability, the statute is too strict in its definitions. He indicated, for example, that the significance of birth-related asphyxia is a topic of controversy currently raging among pediatric experts. Medical evidence increasingly suggests that asphyxia is only a very minor contributor to major birth-related problems. In addition, conditions of permanency can take several years to determine. Eligibility so narrowly defined, according to Mr. Heland, will significantly postpone or deter claims under the compensation act.

Although the law has not been challenged, it raises some constitutional questions. Under Virginia statute, an obstetrician's participation in the plan is optional. If an obstetrician chooses to participate, the injured party's exclusive remedy for damages--unless there is clear and convincing evidence that injuries were intentional or willfully caused--is limited to the benefits provided under the plan. An argument could be made that subjecting a patient to such a variable violates legal rights to equal protection, access to courts, and trial by jury.

Legislation in Other States

Florida is the only other state with legislation addressing birth-related neurological injuries. The statute, which is based on Virginia's and is very similar to it, was enacted in a special session in February 1988, and went into effect January 1, 1989. Pamela Burch Fort, staff director of the Florida Senate Committee on Insurance, noted that although the Florida Medical Association was the only supporters of the bill, dissenting members have now filed suit against it, claiming unconstitutionality.

Although malpractice liability insurance for obstetricians was more readily available in Florida than in Virginia, Florida obstetricians supported the law as a means to reduce premiums. Ms. Burch Fort indicated that the number of infants who qualify under the plan has not been determined. Estimates range from 60--based on a closed-claim study--to 376 per year. The variation is due to difficulties arising from eligibility definitions. The committee has concluded, however, that a permanent and total disability claim on a present value basis would total approximately $1 million. Less severe claims or less

than total disability would represent a cost of approximately $400,000. The cost of 60 claims might conservatively total $45 million per year. On a fully funded basis, program assessments would total only $22 million per year--far short of the most conservative estimated need. The committee further noted that closed-claim studies do not reflect birth-related neurological injuries which have not been litigated. The committee assumes, therefore, that the frequency of claims will probably increase under the compensation plan. Thus, whether or not costs, and therefore premiums, will be reduced is uncertain.

Other states have proposed or established no-fault systems of compensation for medical injuries, but according to Mr. Heland, only those in Virginia and Florida deal specifically with birth-related neurological injuries.[1]

Efficacy of a Birth-Related Neurological Injury Compensation Act in Alaska

Questions of constitutionality and other problems associated with both Virginia's and Florida's compensation programs--and uncertainty about whether or not costs will be reduced--diminish the possibility that a similar statute in Alaska would benefit physicians or consumers. Removal of catastrophically injured babies from the tort system of remedies might reduce premiums if the difficulties--including the problem of determining permanent birth-related neurological injuries--could be overcome. As Mr. Heland put it, "the idea might be a good one if it were debugged and improved upon." Jan Johnson, claims manager of the Medical Indemnity Corporation of Alaska, concurred and noted that a no-fault compensation program which provides a lump sum award is both more costly and less effective than a structured settlement or annuity which provides periodic payments for true medical and care needs and for lost income. Neither recommended implementation of a statute similar to Virginia's or Florida's.

I hope that this information is of use to you. Please call me if you have questions or need further information.

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[1]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. The program works, according to Ken Heland, because babies delivered for county patients are not counted in per delivery premium calculations. Mr. Heland commented that unless a state implements a similar system, premiums would probably not decline.

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

ALASKA STATE LEGISLATURE
HOUSE OF REPRESENTATIVES
RESEARCH AGENCY

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January 28, 1988

MEMORANDUM

TO: Representative Mike Navarre

ATTN: Pat Malone

FROM: Heidi Borson-Paine HBP
Legislative Analyst

RE: Kentucky Patients' Compensation Plan
Research Request 88.120

You requested this agency to provide information on the patients' compensation plan proposed by Carl Wedekind, Jr., President and Chief Executive Officer of the Kentucky Medical Insurance Company. In addition to background information on the proposal, you requested a copy of any related legislation in Kentucky and asked us to address the following questions:

- what safeguards would be built into the proposed patients' compensation board to ensure claimants receive fair and just compensation; and

- what would be the proposal's actual net impact on medical malpractice premiums?

At your request, we contacted Mr. Wedekind, the Kentucky Department of Insurance, and the Kentucky Academy of Trial Attornies to obtain their views on the proposed insurance plan. This memorandum presents a brief overview of the patients' compensation plan, discusses the status of the proposal in Kentucky, addresses your questions concerning safeguards to ensure fair and just compensation and the plan's net impact on medical malpractice premiums, and presents comments from trial attorneys and insurance industry representatives.

OVERVIEW OF THE PATIENTS' COMPENSATION PLAN

The patients' compensation plan adopts a no-fault approach to compensating tnose injured in the health care system, similar to the approach used by the workers' compensation system. The plan compensates injured persons, regardless of fault, for lost wages and medical expenses, but excludes injuries which were inherent risks of a particular medical procedure. Furthermore, proof of negligence is required only when the injury results in death.

Under the proposed plan, claims are determined administratively by a fifteen member patients' compensation board assisted by an advisory board of medical specialists. In addition to handling questions of inherent risk, the advisory board also reviews all incidents where medical negligence is indicated. The plan also adopts the limits on claimant's attorney fees currently legislated for workers' compensation cases in Kentucky (15 to 20 percent of the award, not to exceed $6,500).

As previously noted, Mr. Wedekind is President and Chief Executive Officer of the Kentucky Medical Insurance Corporation, a doctor-owned insurance company providing medical malpractice insurance to approximately half the doctors in Kentucky. Mr. Wedekind based the patients' compensation plan on findings that over 60 percent of all dollars his company expends on medical malpractice cases are spent on attorney fees and court costs to determine fault. The intent of Wedekind's plan is to reallocate the expenditures so that claimants receive more of the payments and the legal system receives less. We have attached an article by Mr. Wedekind which fully describes his proposal (see Attachment A).

STATUS OF THE PATIENTS'COMPENSATION PLAN IN KENTUCKY

The Kentucky Insurance and Liability Task Force was created by the General Assembly during the 1986 regular session. The task force was established "to study and investigate the entire insurance industry, including the Kentucky Department of Insurance," with special emphasis on the availability and affordability of liability insurance.

One of the proposals considered by the task force was the patients' compensation plan. Mr. Wedekind, incidently, served on the task force. Some task force members disputed the appropriateness of such a radical change from the present civil justice system and questioned whether the income benefits under the patients' compensation plan would adequately compensate a seriously injured person. However, the majority of the task force maintained that the costs of medical malpractice insurance is impairing health care delivery in Kentucky and voted to endorse the no-fault patients' compensation plan as a possible solution to the medical malpractice problem.

The task force submitted its recommendations to the General Assembly in December 1987. According to Tom Dorman, Staff Administrator for the task force, it is now up to the General Assembly to decide what to do with the recommendations. Mr. Dorman said he is uncertain about how legislators will react to the patients' compensation plan. While a draft of a bill establishing the patients' compensation system was included in the task force report, the bill does not yet have a sponsor (see Attachment B for a copy of the bill draft).

SAFEGUARDS TO ENSURE FAIR AND JUST COMPENSATION

Mr. Wedekind contends that safeguards to ensure fair and just compensation would be written into the regulations governing the activities of the patients' compensation board. In addition, he maintains the patients' compensation plan ensures fair and just compensation to claimants as the result of two additional factors: 1) anyone injured in the medical system is compensated regardless of fault (except in the case of death or when the injury is an inherent risk); and 2) compensation for all medical expenses and actual lost wages is limited and based on a formula similar to that employed by the workers' compensation system. In cases of total or permanent partial disability, income benefits may not exceed 66-2/3 percent of the patient's average weekly wage. Furthermore, in cases of permanent partial disability, benefits are limited to 425 weeks. Medical expenses are limited to "such charges as are reasonable for similar treatment of injured persons of like standard of living in the same community."

In addition, Mr. Wedekind points out that patients may file a petition for reconsideration of a patients' compensation board decision. If dissatisfied with the board's final decision, the patient may then petition the Circuit Court for review of the decision. Under the proposed plan, however, the review of the court is limited to specific tasks such as determining whether or not the board acted in excess of its powers or whether the board's decision is erroneous on the basis of evidence contained in the record. The judgement of the Circuit Court is subject to appeal to the Court of Appeals.

As indicated in a following section, some trial attorneys contend the compensation limits under Mr. Wedekind's impede fair and just compensation. Mr. Wedekind acknowledges that critics may assert that the compensation limitations are unfair to the injured. However, he points out that the system works well in workers' compensation cases in Kentucky and that the compensation schedule does cover the major part of true economic losses. He also concedes that the patients' compensation board would be susceptible to abuses like those experienced under the workers' compensation board. According to Mr. Wedekind, the workers' compensation board shows a history of increasing generosity of awards.

POTENTIAL IMPACT ON MEDICAL MALPRACTICE PREMIUMS

While no studies have been conducted to determine the actual net impact of Mr. Wedekind's plan on medical malpractice premiums, some research has been conducted on the no-fault approach to medical malpractice insurance in general. According to these studies, more claims will be made under a no-fault system than under a tort system. Study findings on the fiscal impact of no-fault insurance are inconclusive because the costs of the increased claims cannot be determined.

Currently, the sole source of information on the potential fiscal impact of the patients' compensation plan is Mr. Wedekind's study of 268 closed claims handled by the Kentucky Medical Insurance Company. The total cost of the 268 claims, including indemnity payments and defense costs, was $7,845,679. Of the total paid on these claims, 38 percent ($2,988,532) went to the plaintiff, whereas 62 percent ($4,857,146) went to attorneys and costs. Under the patients' compensation plan, a claimant's attorney fees are limited to 20 percent of the first $25,000 of the award and 15 percent of the next $10,000, not to exceed $6,500. Mr. Wedekind claims that this will reduce the costs to claimants by an average of over 60 percent. Mr. Wedekind also anticipates a 60 percent reduction in defense costs under the proposed plan, based on the current defense attorney costs in workers' compensation cases.

Mr. Wedekind performed a cost analysis of the 100 most recent claims from the 268 closed claims to compare the amount and distribution of payments under the current tort system with the anticipated payments and distributions under the proposed patients' compensation plan. The 100 closed claims resulted in total insurance costs of $8,064,156, with claimants receiving $3,585,050 of that amount. Under the patients' compensation plan, Mr. Wedekind estimates that those same 100 cases would result in total insurance costs of $4,358,232, with claimants receiving $3,938,473. For a fuller discussion of Mr. Wedekind's comparative cost analysis, please refer to page 173 of Attachment A.

The Bureau of Economic Research at the University of Louisville has applied for a grant from the Robert Wood Johnson Foundation to study the no-fault patients' compensation concept. According to John Nelson, author of the grant application, the study would examine the economic and social impacts of the no-fault approach to medical malpractice insurance, as well as other alternatives for addressing the medical malpractice problem. One focus of the study would be the net impact of the patients' compensation plan on medical malpractice premiums. If the grant is approved, the study would run from November 1988 through December 1989 with the intent of having legislation ready for the 1990 legislative session.

COMMENTS FROM TRIAL ATTORNEYS AND INSURERS

Sharon Helton, Executive Director of the Kentucky Academy of Trial Attorneys, contends the patients' compensation plan is "an insane proposal." She predicts that if a bill is introduced this legislative session, it will not pass out of its first committee of referral. According to Ms. Helton, not only do trial attorneys oppose the no-fault insurance plan, the Kentucky Medical Association also voted against the plan at a recent meeting. Ms. Helton claims that physicians oppose the patients' compensation plan because it turns each patient into a potential claim.

Ms. Helton cites the following arguments against the proposed plan: 1) the no-fault concept is inappropriate in the health care field because physicians do make mistakes and need to be held accountable for them; 2) no attorney could afford to take a case under the proposed no-fault system because the fees are set so low; 3) no safeguards have been built into the patient compensation board to ensure fair and just compensation; and 4) the plan does not allow awards for pain and suffering.

Furthermore, Ms. Helton contends it is inappropriate to fashion a patients' compensation plan after Kentucky's workers' compensation system because that system is currently running out of money. In fact, the workers' compensation system was recently the subject of a special legislative session in Kentucky.

Charles Wible, an attorney who served on the Kentucky Insurance and Liability Task Force, filed a dissent to the task force report. In his dissent, Mr. Wible called the patients' compensation plan "a prime example of special interest legislation which can only benefit the insurance industry and the medical profession." In addition to the arguments cited above, Mr. Wible claims the plan would create another layer of state bureaucracy to handle medical malpractice claims and contends that citizens injured by negligent health care providers must be allowed "to have their day in court before a jury of their peers, rather than be subjected to the limitations inherent in the patients' compensation proposal."

According to Commissioner Gil McCarty, Kentucky Department of Insurance, the department has not taken a position on the proposed patients' compensation plan. Commissioner McCarty, who participated on the task force, acknowledges that the plan has generated a lot of controversy and is a "radical departure" from anything he has seen in the insurance industry. However, he is not opposed to trying the plan in Kentucky for a few years to see how it works. The Department of Insurance has not conducted any studies on the plan's possible fiscal impacts. However, if a patients' compensation bill is introduced this session, the department will prepare a fiscal note for the bill.

Commissioner McCarty states he is not personally aware of the insurance industry's position on the proposed plan. However, Tom Dorman, Staff Administrator to the legislative task force, contends the insurance industry actively participated in the task force review process and has problems with the proposal in general. Of the two underwriters for physician malpractice insurance in Kentucky, one formally opposed the plan and the other did not submit a position paper.

* * *

I hope this memorandum addresses your questions. Please contact me if you need any additional information.

Attachments

ATTACHMENT A
Article from Alaska Medicine,
November/December 1987

Special Feature

An Alternate Proposal for Compensating Injuries Occurring in the Health Care Delivery System

by Carl L. Wedekind, Jr., LL.B.[1]

ABSTRACT

This paper proposes adopting a no-fault approach to compensating injuries occurring in the delivery of health care, similar to the original approach under the Workers' Compensation system applying to injuries occurring in the work place. The proposal is based on the statistical evidence that over 60% of all the dollars spent on medical malpractice cases are spent to pay costs and attorney fees to determine fault.

The proposed Patients' Compensation system would determine claims administratively by a 15-member Board, assisted by an Advisory Board of medical specialists, which would also serve as a peer review board of all incidents where medical negligence is indicated.

The plan would compensate injuries on the basis of lost wages and medical expenses, but would exclude injuries which were inherent risks of the treatment modality and would still require proof of negligence where the injury results in death.

A statistical review of the costs of 100 closed claims under the current tort system compared with similar costs under the proposed Patients' Compensation system discloses that savings of almost 50% would be achieved under the Patients' Compensation system with the injured party receiving more net benefits than he is now receiving under the current tort system.

Tort reform is being seriously debated and acted upon in many of the State Legislatures and in the Federal Congress. Proposals vary but frequently break down to the categories of a) limiting the amount of recovery, b) regulating contingency fees for attorneys, c) allowing credit for collateral source payments available to the injured party, d) providing for periodic payments rather than lump sum award, e) establishing economic incentives to promote a prompt resolution, and so forth (1). The nagging question keeps surfacing, "Will any of these measures help in the availability and cost of liability insurance?", and "Are these proposals fair?"

This proposal addresses a system of reform which will, if carried out properly, help directly in both the cost and availability of professional liability insurance for physicians, hospitals, and other health care providers and is intended to contain the basic tenets of fairness. The proposal is the result of several years of research and review and embodies a number of ideas from different sources and the thoughts and experiences of the author (2). No claim of originality is made unless it be in the perceived uniqueness of the overall plan.

This proposal relates only to medical professional liability insurance problems, because of the conviction that the area of medical malpractice is unique in the tort system and should be dealt with separately from other liability insurance problems.

The basic assumptions that form the framework of the proposal are these:

1. Persons who are injured in the health care system should be compensated.
2. Persons, or institutions, responsible for such injuries should be held accountable.
3. Provable fault should not be a requisite to recover compensation for an injury other than death.
4. The inherent identifiable risk of any modality of treatment should be excluded from coverage, and that risk insured through a separate mechanism.
5. The current tort system for determining medical malpractice has a serious economic flaw as the majority of all claims dollars are being spent to determine the question of fault.

The statistics that led to this proposal are the results of closed claims studies done by the Kentucky Medical Insurance Company (KMIC) a physician owned medical malpractice company. These statistical studies are similar in results to closed claims studies done by other medical malpractice carriers (3).

The 30-month period covered by this study is from January 1, 1984 to June 30, 1986, and includes all medical malpractice claims closed by KMIC in that time span.

Of the 268 closed claims studied it was determined that in 112 cases (42%) there was liability. That is, there was a recognized standard of care that had not been met.

[1]Reprinted with permission from A. M. Best Co., Best's Review, May 1987. Published also in the Journal of the Kentucky Medical Association, 1987;June:317-322.

The average indemnity payment to the plaintiff for all 112 liability cases was $53,367. The average cost to defend these 112 cases (defense lawyers, expert witness, depositions, court costs, etc.) was $8,166 for a total average cost on liability cases of $61,533.

On those cases where we, or a judge or jury, determined there was no liability (156 cases, 58%), there were zero indemnity payments made and the average defense cost per claim was $5,304.

The total 268 claims cost, for both indemnity payments and defense costs, was $7,845,679. The breakdown is as follows:

Indemnity payments	$5,977,065
Defense costs	1,868,614
Total	$7,845,679

The indemnity payments are made directly to the plaintiff and his or her attorney. We are advised that the average contingent attorney's fee on medical malpractice cases in the Kentucky area currently is 40%, and the plaintiff's expert witness, depositions, and other costs are on top of that and can be currently estimated at about 10%. So the plaintiff receives approximately 50% of the indemnity settlement (4).

Thus the use of the $7,845,679 total paid out on these 268 claims breaks down as follows:

To the Plaintiff	$2,988,532	38%
To the Plaintiff's attorney and costs	2,988,532	38%
To the Defendant's attorney and costs	1,868,614	24%
Total	$7,845,614	100.0%

Thus of the total $7,845,679 paid on these claims, 62%, $4,857,146 went to attorneys and the cost of the system.

The object of this proposal is to achieve reallocation of those dollars so that the claimant will receive more of the total dollars spent, and the system will receive less. This can be achieved through a modified no-fault system patterned somewhat after the Workers' Compensation laws, which this proposal calls "The Patients' Compensation Plan" (5). The basic tenets of this plan are these:

1. Those who are injured in using the health care system should have a source to recover reasonable compensation for those injuries, regardless of fault.

2. Such compensation should be paid by the health care provider in some instances and should be borne by the patient in some instances, the test being:

a. If the injury is the result of an inherent risk, previously identified and made known, of the health care procedure being followed, then the economic burden falls on the patient who will have access to health and accident insurance to cover the risk.

b. If the injury is due to some other cause within the health care delivery system, either negligence or unknown cause, then the economic burden falls on the health care provider, who will have access to liability insurance to cover the risk.

3. The procedure for determining reasonable compensation to be paid by the health care provider is a procedure similar to Workers' Compensation whereby medical costs and lost income are dealt with on an actual, as occurring basis, and the claimants legal fees are regulated.

4. Cases in dispute would be heard by a hearing officer as in Workers' Compensation and decided by a Patient's Compensation Board similar to the Worker's Compensation Board, with two major additions:

a. The Patient's Compensation Board would have an advisory board of medical specialists to render opinions on "inherent risk" questions and technical medical questions.

b. The Patient's Compensation Board would have, as part of its operations, procedures for peer review of all medical procedures involved in claims and prompt referral to licensure boards or regulatory bodies of incidences of apparent deviation from a reasonable standard of care.

5. Each patient would have the opportunity to elect not to be covered under the system, just as each worker can elect not to be covered by Workers' Compensation, in which case a claim for an injury would be dealt with in the existing court system.

6. The plan would cover all aspects of the health care system and all the licensed professionals and institutions.

7. Some of the details of the procedures are as follows:

a. Each patient entering the health care delivery system would come under the plan, unless he elected in writing not to. Each health care professional and institution would be required to come under the plan.

b. The "inherent risk" would have to be determined in advance and specified in writing, as is currently done under the doctrine of "informed consent." These determinations would be made by the health care professional with the assistance of his specialty society or the Advisory board to the Patients' Compensation Board.

c. When a compensable incident occurs, the patient must give prompt notice, and a claim must be brought within one year of the occurrence, with a five-year cap for discovery, and by a minor under six, by his eighth birthday.

d. Compensation will be paid in the form of all necessary medical attention and lost wages under a formula similar to the Workers' Compensation formula. When the injured party is a non-wage earner, compensation can be paid for lost services or for future lost wages.

e. Compensation can be offset by other collateral sources of payment available to the patient, less the cost of obtaining such collateral source. Compensation is limited to economic losses.

f. Rehabilitation is a major part of the recovery benefits, as it is in Workers' Compensation.

g. Death is a compensable event only when there has been negligence as a causative factor.

h. Special provisions are made for emergency treatment where inherent risk can't be communicated and where there is no real opportunity for a patient to elect to come under the act.

i. Compensation can be increased where there is serious fault and decreased when the patient does not follow instructions.

j. Continuing physical exams of claimant can be required, and medical and hospital bills must be reasonable and are under the control of the Board.

k. Cases may be subsequently reopened where the disability has improved or worsened.

l. Attorney's fees for the claimant are limited to 20% of the first $25,000 of recovery, 15% of the next $10,000 and in no case to exceed $6,500. These fee limitations are identical to the current Workers' Compensation act in Kentucky.

m. The Patients' Compensation Board of 15 members are split with five members from the health care delivery system, five from the legal profession, and five from the public.

n. The Board would have hearing officers who would gather the facts and make recommendations, as in Workers' Compensation.

o. The Board would receive administrative services from the State Department for Human Resources, or a like governmental Agency.

p. The Advisory Committee to the Board would be all health care professionals with access to Ad Hoc Committees from all the specialties and institutions.

q. There would be continuing peer review by the reporting of incidents to the Board, and the review of such incidents to the Board, and the review of such incidents by the Advisory Committee with referral to the licensuring boards where appropriate.

r. Patients coming under Federal Tort Law would be exempt from this act.

s. No cases would go to court for a jury trial. There would be limited appeals from Board decisions to the Circuit Court.

t. Insurance will be available to health care providers, who may also become self-insured or pool their risk as currently in Workers' Compensation.

u. Insurance will be available to patients to cover inherent risks, and would be health and accident insurance policies somewhat similar to "trip insurance."

v. There are penalties for bringing claims without reasonable grounds.

The major changes that this proposal will bring over the current tort system are set out below, with some comments pro and con on their anticipated effects.

a. Everyone who is injured in the system would be compensated without regard to fault, except in the case of death, or when the injury is an inherent risk.

Many observers believe that a "no-fault" system would bring to the surface many injuries that are occurring in the health care system and are not being prosecuted now because of the cost and difficulty involved. They believe that even through the proposed system might be less expensive on the known claims, the "unknown" claims that would come to light would cause expenses to soar (6).

My response is that there probably are a lot of injuries that the proposed system would uncover—but if they are occurring why shouldn't they come to light? To the extent that these new claims are exposed, economic pressures would work towards eliminating the causes. The costs of these injuries are now being borne by some segment of society and the more we know about them the better we could deal with them.

Death is excluded from the no-fault system because almost all deaths take place within the system and can't be compensable unless there was negligence in causing the death.

b. All injuries would be reported to a responsible body for peer review and appropriate steps could be taken to eliminate the causes.

Currently a negligent act in the delivery of health care can result in monetary damages paid by an insurance company, but little else happens. Under Kentucky law the insurance companies report all claims payments to the Department of Insurance which in turn advises the Kentucky State Board of Medical Licensure of the name of the doctor and the amount of the settlement, and if a doctor gets enough paid claims against him the Medical Licensure Board will look into it. This is far short of an efficient on-going process of review of the quality of medical care. This proposal provides the mechanism and makes it mandatory, that continuing peer review of quality of care be performed, and ties the system directly into the responsible licensing authorities and brings the scrutiny not only of doctors, but on all providers in the health care delivery system.

Critics will most likely say we will be creating another bureaucracy that will interfere and hassle the health care system, and make it more expensive. In my opinion the review system would have to be well run, or the critics could be right.

c. The identification of inherent risks and the elimination of compensation for such risk.

The technological and scientific developments in diag-

nostic techniques and treatment and the invasiveness of many of these, and the development and use of new drugs, all lead to increasing risks in our health care system. This proposal requires that these inherent risks be determined and disclosed in writing and in advance to the patient. This is currently being done (or should be done) to satisfy the requirements of "informed consent." There is often the question of "how great is the risk" and might the patient be better off not knowing some of the risks. This proposal is in favor of disclosure and the patient knowing the risks. It is believed that the pressures to determine and disclose risks in order to avoid possible liability, in conflict with the often existing pressures to proceed with treatment and minimize any real analysis of risks, will result in an accommodation where risk will be determined and disclosed in a reasonable manner. There is also, as part of this proposal, an Advisory Board to the Patients' Compensation Board made up of medical expert professionals who will assist in determining inherent risks and in settling disputes concerning them.

There are conflicting views on the treatment of risks in modern medicine and some of those concerned with hospital occupancy and expensive procedures may feel that the disclosure requirements are too stringent, and not necessary, and not in the patient's best interest. The author of the proposal believes otherwise:

Where injuries occur because of an inherent risk in any procedure, there will be made available accident and health insurance applicable to these inherent risks that an individual is assuming, and this insurance will be available like "trip insurance" for a premium to each patient as he enters the system. This "trip insurance" will be offered by private insurance carriers (7).

d. The proposal would change the current statute of limitations applied to minors.

The proposal adopts the existing statute of limitations in Kentucky on medical malpractice claims for adults of one year (with five years for discovery), but changes the rule as to minors. Currently no limitations run against minors until they reach their 18th birthday, and the proposal changes this so that the statute starts to run at age six. This means that a parent or guardian would have to assert a claim for a minor over six year of age in the same way a claim has to be made by an adult.

Critics will assert that this is unfair to impose on one who cannot fend for himself and may later disagree with a parent or guardian's decision on prosecuting a claim. I believe, in fact, almost all serious claims involving minors are brought promptly by the parent because of the economic necessities, and leaving the door open for a claim for as much as 23 years brings unfair uncertainty and exposure to pediatricians and obstetricians. Many states have adopted similar statute of limitations for minors (8).

e. The proposal will do away with jury trials.

There will no longer be any necessity for a jury trial to determine fault. The questions will be: was there any injury; was it caused by the health care system; was it an inherent risk. If the answer to the first two questions is yes, and to the third question is no, then an award must be determined. All of these decisions will be made by an Administrative Board in informal procedures with very little expense.

If the concept of no fault is accepted then there can be little criticism of eliminating jury trials. They are not needed. But critics will object as the right to a jury trial lies deep in our anglo-saxon experience over some 800 years. It has been our major civil system for holding people accountable for their acts.

It is the foundation of this proposal that jury determination of fault in a medical malpractice case is so expensive we can no longer afford it, and therefore we do away with fault in awarding compensation and substitute a more efficient and professional system of accountability through peer review of all accidents and claims. We eliminate the expenses, but maintain the deterrence.

Critics will also question the creation of another Board, another government bureaucracy, another political entity and the further intrusion of government in the private practice of medicine. These are serious concerns. But the bottom line is the private practice of medicine is already a public matter and the cost of medical malpractice is a public concern and the purpose of government is to deal effectively with social problems. We have a social problem and if government is further involved we must see to it that it is done effectively.

f. Attorney fees are regulated.

The proposal adopts the regulation of claimant's attorney fees that is now the law in Kentucky in Workers' Compensation cases — 15% to 20% of the award, not to exceed $6,500 in any case. This will reduce these costs to claimants, on average, by over 60% (9).

Additionally, the defense attorney costs on a contested case in Workers' Compensation average between $2,250 and $2,500. This reduction over current defense costs will also average over 60%. These savings, along with savings on expensive expert witnesses, and the recoveries from collateral source prepaid medical insurance are the economic basis that will make this proposal work.

g. The proposed compensation benefits are limited, exclude any award for pain and suffering, and the plan takes advantage of some collateral sources available for reimbursement.

The proposal has adopted the payment schedule currently in effect in Kentucky for Workers' Compensation which pays all medical expenses, actual lost wages and a cap equal to the average wage in Kentucky, and no

award for pain and suffering.

Critics may assert that the limitations are arbitrary and are unfair to the injured. They could be right, it depends upon your perspective and beliefs concerning the allocation of resources. The system was chosen because it actually works fairly well in Workers' Compensation cases in Kentucky and it does cover all, or the major part, of the true economic loss, and it has the flexibility to be increased of decreased according to the future needs of the injured party. It there are adequate resources available the structure of the awards could be increased and awards of pain and suffering could be included. It is my belief that this should not be considered until some experience has been achieved with the plan in effect.

In many of our states, including Kentucky, there are serious problems over the increasing costs of long standing Workers' Compensation systems and the question logically arises whether the proposed Patients' Compensation system will inherit these cost problems. The answer initially at least, is no. In Kentucky, for instance, the major increases in costs have developed from the Special Fund and the Kentucky Reinsurance Association; neither of which are involved in the traditional Workers' Compensation insurance system, and neither will exist under the Patients' Compensation system.

It is true, however, the largess of a state legislature or of the courts can subsequently effect any system of compensation for injury, but the specific terms of this Patients' Compensation proposal will hold costs to reasonable and predictable levels. These costs are projected in detail in the next section of this paper.

b. Comparative cost analysis.

A group of 100 closed claims handled by the Kentucky Medical Insurance Company under the existing tort system were selected for a cost analysis to compare the actual amount and distribution of payments under the tort system with the anticipated payments and distributions under the proposed Patients' Compensation system. This group of claims are from the same 30-month study group referred to earlier in this paper, but were selected from the most recent period to more adequately reflect our current results (10).

These closed claims run the gamut from the very serious to the very trivial: some were settled, some went to trial, and some were dismissed or abandoned. We know the actual costs under the tort system and we have determined the probable costs under the Patients' Compensation system.

These results clearly disclose the waste of economic resources in trying to determine fault under the current tort system, and how a Patients' Compensation system, properly administered can produce better net benefits to the injured parties for about half the cost.

This comparative cost analysis is set forth in Table A.

I envision a system where an individual entering any health care facility would become a member of the Patients' Compensation plan and would be informed of the inherent risks, if any, of the treatment he is to receive. He will have available to him health and accident insurance to cover those inherent risks. He will further have the Patients' Compensation plan to provide benefits if he is injured by negligence or unknown cause. In the event of such injury, he or his family would fill out a simple claim form which would be processed by the health care facility or its insurance carrier. A prompt determination would be made if this was an injury which was not an inherent risk, and a prompt determination of benefits for lost income and medical expenses would be made and would be paid. If there is evidence of negligence by any health care provider, the claim will be referred by the Patients' Compensation Board to its medical specialist Advisory Board which would review the facts of the claim and if necessary refer the matter on to the appropriate licensing authority for peer review and remedial action.

Absent from this system are the costs and delays that

Table A
Comparison of Payments and Distribution
100 Closed Files

Tort System		Patients' Compensation System	
Total Paid	8,064,156	Total Paid	4,358,232
Indemnity Payments	7,170,099	Indemnity Payments[12]	4,165,732
To Claimant	3,585,050	To Claimant[13]	3,938,473
To Claimant's Attorney[4]	2,868,049	To Claimants' Attorney[14]	180,759
To Costs[4]	717,000	To Costs[14]	46,500
	7,170,099		4,165,732
To Defendant's Attorney and Costs[11]	894,057	To Defendant's Attorney and Costs[15]	192,500
	8,064,156		4,358,232
Total Insurance Costs[16]	8,064,156	Total Insurance Costs	4,358,232
Net to Claimants	3,585,050	Net to Claimants	3,938,473

have become the most prominent feature of determining fault under our current Court system.

What is proposed is that one or more states establish a five-year experimental program to test the fairness and efficiency of the proposed Patients Compensation system; enact the legislation which is detailed in this proposal with a five-year sunset provision and establish methods for monitoring the effects on those injured, as compared to the general results currently under the tort system, and monitoring the cost to the insurance carriers offering the Patients' Compensation coverage (17). If the studies done thus far are correct there should be a substantial reduction in cost without a concomitant net loss to those injured in the health care system.

NOTES

1. *Business Insurance,* August 18, 1986, presents the most recent compilation of State Legislative actions during 1986 in tort reform. More than 16 states have adopted some cap on non-economic damages, 13 states have statutes allowing for periodic payments, 6 states regulate attorneys contingent fees, and 11 states have recently enacted statutes allowing for credit for collateral source payments. A number of other state legislatures enacted similar legislation during the medical malpractice crisis in the mid-seventies.

In Congress, the *Moore-Gephardt Bill* (H.R. 3084, the "Medical Offer and Recovery Act") is pending before the Ways and Means Committee, and has been under consideration for the last several years. This proposal is to encourage prompt offers of settlement in medical malpractice cases and to limit recoveries to economic damages. The Bill contains an approach recommended by Professor Jeffrey O'Connell of the University of Virginia Law School. See: H. Moore, J. O'Connell. "Foreclosing Medical Malpractice Claims by Prompt Tender of Economic Loss." Louisiana Law Review, Volume 44 #5, May 1984.

There has also been introduced in Congress the "Federal Tort Claim Reform Act of 1986," the "Government Contractor Liability Reform Act of 1986," and the "Product Liability Reform Act of 1986," all supported by the Administration and dealing with many of these same proposed remedies.

2. The author, Carl L. Wedekind, Jr., is an attorney (University of Virginia. 1950) who was in the private practice of law (Stites and Harbison) in Louisville, Kentucky from 1954 to 1981. He specialized in civil law including tort litigation (primarily, but not exclusively, for Defendants) and general corporate and insurance law. As attorney for the Kentucky Medical Association he set up a physician-owned medical malpractice insurance company (the Kentucky Medical Insurance Company) on behalf of Kentucky doctors and served as General Counsel and Director (1978-1980) and in 1981 became President and Chief Executive Officer of Kentucky Medical Insurance Company, in which capacity he still serves.

The author has been aided by too many people and their individual ideas to attempt to list, with the exception of two: Mr. Glen Schilling, a prominent Louisville attorney and past-president of International Association of Industrial Accident Boards and Commission, and a member of the Kentucky Workmen's Compensation Board, who provided technical expertise in regard to Workmen's Compensation law: and Mr. Larry Hamfeldt, also a prominent Workmens' Compensation attorney, who assisted in doing the economic closed claims study in converting the costs of cases under the tort system to the proposed Patients' Compensation system.

3. The Physicians Insurers Association of American (PIAA) compiles data from all the physician owned medical malpractice carriers, and the consistency of the data can be seen in their periodic reports. The most recent is the "1985 PIAA Data Sharing Reports," covering 4,760 closed medical malpractice files.

4. The Plaintiff's attorney's contingent fee and costs is an estimate based on informal polls conducted by the KMIC claims department personnel. The amount will vary depending on rural-urban considerations, and the seriousness and difficulty of the case. The average contingent fee selected is 40% of the gross recovery with additional expenses estimated at 10%.

5. A Workmens' Compensation type approach is under consideration in a number of forums. In Missouri, Representative Banton introduced H.B. 1628, "Medical Injury Compensation Law" which limits recovery to economic losses but does require the proof of negligence. No reported action was taken in the Legislature on this bill.

In Michigan, during the 1977 Legislature, a bill was introduced for the establishment of a State Medical Compensation Board, but the bill was not passed.

In Florida, State Senator Dempsey Barron introduced. "An Act Relating to Medical Incident Compensation," which would remove malpractice disputes from tort law and place them in equity under contract law and thus eliminate a jury trial. The 1985 Legislature failed to act on this bill.

The Workmans' Compensation approach has also been supported by a Tallahassee, Florida attorney, Frederick B. Karl, and a Wharton School of Finance professor, Patricia M. Danzon.

There may well be others that have not come to the author's attention.

6. The "Alliance of American Insurers" for instance established the Alliance Medical Malpractice Task Force which reviewed the issue of Workmens' Compensation type schedules for malpractice claims. Mr. John P. Waligore, attorney for the Alliance, reported to my

colleague, Glen Schilling (by letter of May 22, 1986), "Our Task Force rejected this approach because we viewed it as inappropriate at both the state and federal levels. We felt that such a system would not cut total claim costs because it could increase the frequency of claims brought significantly. Such a system would make claims much easier to bring and would make the certainty of an award much greater. The Task Force believed that a Workers' Compensation type system would probably increase total claim costs because claims that would formerly have been of too small value to merit filing an action in court and not be brought administratively. The Alliance does not recommend support for such a system.

7. The Kentucky Medical Insurance Company is prepared, subject to the approval of the appropriate State Department of Insurance, to offer this coverage.

8. Alabama provides a minor under four has until his eighth birthday; Indiana provides a minor under six has until his eighth birthday, and the two year statute applies thereafter. The courts in other states, such as New Hampshire, Ohio and Texas have declared provisions similar to these to be unconstitutional under their state constitutions.

9. The current average payment per indemnity case on closed files studied by the Kentucky Medical Insurance Company is $53,000, of which it is estimated 40%, $21,200, goes to the attorney. Thus the proposal would reduce the cost to a maximum of $6,500, a savings of at least $14,700.

10. After the exclusion of duplicate files where there was only one incident but a number of defendants, and the exclusion of some of the trivial claims where there would be no award or significant expense under either system, the remaining files compose the 93 included in the study.

11. Defendant's Attorney fees and costs are actual payments made in the 100 closed files.

12. Indemnity under the proposed Patients' Compensation plan is a combination of lost earnings, past medical expenses incurred and estimated future medical expenses. For the 100 cases, the total past and estimated future lost wages were computed on the Kentucky Workmen's Compensation formula and discounted to a lump sum payment, and totaled $3,311,996. The medical payments totaled to $2,125,909 before recovery of health insurance reimbursement, which was $1,272,172 leaving net medical payments of $853,737.

Industry estimates in Kentucky are that 85% of the population has some type of prepaid health insurance covering an average of 75% of total costs, .85 x .75 = .64. From this recovery we deduct the estimated premium paid for the health insurance ($75.00 per month) for a 2-year period, $1,800 per case. This computation results in the net medical payout of $853,737. Thus, the total indemnity of lost wages and past and future medical expenses totals $4,165,732 for the 100 cases.

13. This is net to claimant after deducting estimated costs and attorney fees.

14. Claimants' costs for attorneys in contested claims are regulated by the proposal in the same way they are regulated in Workmens' Compensation cases — a contingency fee limited to 20% of the first $25,000 lost wages recovered, 15% of the next $10,000, with a $6,500 cap. On the 100 closed claims studied, there were 19 cases where the full $6,500 fee would be earned, for a total of $123,500 and the total of the remaining awards produced an additional $57,259 in attorney fees, for a total of $180,759.

The additional costs for presenting the claims is estimated at $1,500 per case times an assumed 33% of the cases (31) .31 x 1,500 = $46,500.

15. The Defendant's costs for attorney's in contested 'Workmens' Compensation cases in Kentucky are not regulated and it is estimated in the industry that the average costs to defend these cases is between $2,250 and $2,500. We selected $2,500 as the average amount to be used and applied it to every closed claim in which we had paid defense costs. This was 77 out of the 100 files for a total cost to the defendant of $192,500.

16. These costs include payments made by all defendants in these closed claims, and thus are significantly higher than the earlier study which only included KMIC's costs.

17. The Kentucky Medical Insurance Company will be prepared to offer this coverage, subject to approval of the appropriate State Department of Insurance, on a trial retrospective premium basis.

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ATTACHMENT B
Bill Draft # 33

Bill Draft #33

A PATIENTS' COMPENSATION PLAN

SECTION 1. KRS CHAPTER 311A IS ESTABLISHED AND A NLW SECTION THEREOF CREATED TO READ AS FOLLOWS:

As used in this Act unless the context otherwise requires:

(1) "Incident" means any harmful change in the human organism arising out of and in the course of undergoing health care treatment rendered, or which reasonably should have been rendered, but does not include any result which could reasonably be anticipated as an inherent risk of the health care treatment being received.

(2) "Health care treatment" means any treatment received or course of action followed at the direction of any health care professional or agent or employee of any health care institution for the purpose of health care.

(3) A "health care professional" is any person licensed to practice medicine, osteopathy, chiropractic, podiatry, dentistry, nursing, physician assistant, emergency medical service, midwifery, or any other form of treating or healing art in Kentucky that is now or may subsequently be authorized and licensed by Kentucky law.

(4) A "health care institution" is any entity licensed to provide hospital, nursing, physical therapy, emergency, outpatient, or other health related services that are now or may subsequently be authorized and licensed by Kentucky law.

(5) A "patient" is any individual receiving health care treatment from a health care professional or in a health care institution in Kentucky.

(6) "Inherent risks" are those ordinary risks reasonably apparent to the lay person, and those medical, technical and procedural risks determined by the health care professional or institution and communicated in writing to the patient or his representative prior to his treatment. Such inherent risks are those that exist and occur without a deviation from a reasonable standard of care. When, due to a medical emergency, there is neither time nor opportunity to communicate inherent risks to the patient or his representative prior to treatment, the nature of such inherent risk shall be as determined by the Advisory Board to the Patient's Compensation Board.

(7) "Death" will be considered an inherent risk in certain medical and surgical procedures as defined by the Board on the recommendation of the Advisory Board, and in all such instances, death benefits will be available under this Act only upon a showing by a preponderance of the evidence that death

was caused or brought about by a deviation of a reasonable standard of care by the health care professional or institution.

(8) "Disability" means a decrease of wage earning capacity due to injury or loss of ability to compete, to obtain the kind of work that the patient is customarily able to do, in the area where he lives, taking into consideration his age, occupation, education, effects upon the patient's general health of continuing in the kind of work he is customarily able to do, and impairment or disfigurement.

(9) "Income benefits" means the payment made under the provisions of this Act to the disabled patient or his dependents in case of death, excluding medical and related benefits.

(10) "Medical and related benefits" means payments made for medical, hospital, burial and other services as provided in this Act other than income benefits.

(11) "Compensation" means all payments made under the provisions of this Act representing the sum of income benefits and medical and related benefits.

(12) "Medical services" means medical, surgical, dental, hospital, nursing and medical rehabilitation services, medicines and fittings for artificial or prosthetic devises.

(13) "Beneficiary" means any person who is entitled to income benefits or medical and related benefits under this Act.

SECTION 2. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) Every health care professional and health care institution subject to this Act shall be liable for compensation for any incident resulting fr health care treatment without regard to fault as a cause of the incident.

(2) If the incident occurs to the victim through the deliberate intentions of the health care professional or agent or employee of the health care institution to produce such incident, the victim or his dependents may receive compensation under the provisions of this Act, or in lieu thereof, have a cause of action at law against the health care professional or health care institution as if this Act had not been passed, for such damage so sustained by the victim, his dependents or personal representatives as is recoverable at law. If a suit is brought under this subsection, all rights to compensation under this Act shall thereby be waived as to all persons. If a claim is made for the payment of compensation or any other benefit provided by this Act, all rights to sue the health care professional or health care institution for damages on account of such incident shall be waived as to all persons.

(3) If the incident is caused in any degree by the intentional failure of the patient to comply with the reasonable health care treatment prescribed, the compensation for which the health care professional or institution would otherwise have been liable under this Act shall be decreased fifteen percent (15%) in the amount of payment.

(4) Where a claim is made for an incident arising out of health care treatment in which it is alleged that treatment reasonably should have been rendered, but was not, the Board may seek the advise and assistance of the Advisory Board in determining the question of whether the omitted treatment reasonably should have been rendered.

SECTION 3. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) Any health care professional rendering treatment in the Commonwealth or any health care institution, including any agency of the state, county or city government or any public or quasi-public corporation or entity thereof, providing health care treatment in the Commonwealth shall be subject to the provisions of this Act.

(2) Except for persons seeking exemption under the provisions of subsection (3) every person, including a minor, who receives health care treatment from a health

care professional or in a health care institution shall be subject to the provisions of this Act.

(3) Any person who would otherwise be covered but who elects in writing not to be covered in accordance with the rules and regulations promulgated by the Board shall be exempt from the coverage provided by this Act.

(4) Any person for whom a rule of liability for injury is provided by the laws of the United States shall be exempt from the coverage provided by this Act.

SECTION 4. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) If a health care professional or institution secures payment of compensation as required by this Act, the liability of such professional or institution under this Act shall be exclusive and in place of all other liability of such professional or institution to the patient, his legal representative , husband or wife, parents, dependents, next of kin, and anyone otherwise entitled to recover damages from such professional or institution at law on account of such injury. The liability of such professional or institution to another person who may be liable for or who has paid damages on account of injury of a patient shall be limited to the amount of compensation and other benefits for which such professional or institution is liable under this Act on

account of such injury, unless the professional or institution by written contract have agreed to share liability in a different manner. The exemption from liability given such professional or institution by this section shall also extend to the professional's and institution's carrier and to all employees, officers or directors of such professional or institution or carrier, provided the exemptions from liability given an employee, officer or director or such professional or institution or carrier shall not apply in any case where the injury is proximately caused by the willful and unprovoked act of such employee, officer or director.

(2) If such professional or institution fails to secure payment of compensation as required by this Act, an injured patient, or his legal representative, may claim compensation under this Act and in addition, may maintain an action at law for damages on account of such injury, provided that the amount of compensation shall be credited against the amount received in such action, and provided that, if the amount of compensation is larger than the amount of damages received, the amount of damages less the patient's legal fees and expenses shall be credited against the amount of compensation. In such action the defendant may not plead as a defense that the patient

assumed the risk of his treatment, or that the injury was due to the contributory negligence of the patient .

(3) A professional or institution shall retain all common law defenses against any action by a patient who elects not to be covered as provided under Section 3.

SECTION 5. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) Every health care professional or health care institution subject to this Act shall keep a record of all incidents occurring to patients in the course of their health care treatment. Within one week after the occurrence and knowledge as provided in Section 11, of such an incident to a patient, a report thereof shall be made in writing and mailed to the Board on forms procured from the Board for that purpose.

SECTION 6. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) Where a health care professional or a health care institution is subject to this Act, then every patient of such professional or institution as a part of his contract for becoming a patient, or who may be a patient at the time of the acceptance of the provisions of this Act by such professional or institutional shall be deemed to have accepted all the provisions of this Act and shall be bound thereby unless he shall have filed prior to

the injury or incident, written notice to the contrary with such professional or institution. The Patients' Compensation Board shall not give effect to any rejection of this Act not voluntarily made by the patient. If a patient withdraws his rejection, the professional or institution shall notify the Patients' Compensation Board.

(2) Until notice of rejection is given to the professional or institution, the measure of liability of such professional or institution shall be determined according to the compensation provisions of this Act. Any such patient, may, without prejudice to any existing right or claim, withdraw his election to reject the compensation available under the provisions of this Act by filing with the professional or institution a written notice of withdrawal, stating the date when the withdrawal is to become effective. With the filing of such notice, the status of the party withdrawing shall become the same as if the former election to reject the compensation available under the provisions of this Act had not been made, except that withdrawals shall not be effective as to any injury sustained or incident occurring less than one (1) week after the notice is filed.

(3) When a patient enters the health care system under circumstances where he cannot reasonably exercise his right to elect not to come under the terms of this

Act, such right of election shall be continued for a period of ninety (90) days after such patient or his representative is able to reasonably exercise such election, regardless of the occurrence of any incident during the lapsed period of time.

(4) All notices of rejection of the provisions of this Act by patients shall, when executed, be preserved by the health care professional or institution during the continuation of the rendering of health care treatment to the patient.

SECTION 7. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) The Patients' Compensation Board, the director, or his authorized representative, upon showing a certificate of noncompliance, may temporarily restrain or permanently enjoin the further operation of any health care professional or institution covered by this Act. Such actions shall be brought in Franklin Circuit Court.

SECTION 8. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) The Patients' Compensation Board shall consist of fifteen (15) members appointed by the governor to be divided into five (5) panels of three (3) members each, and shall be attached to the Department of Human Resources for administrative purposes.

(2) Five (5) of the members shall be representatives of health care deliverers, five (5) shall be attorneys with the qualifications of circuit judges, and five (5) shall be representatives of the public, with one (1) member from each group serving on each three (3) member panel, and each panel selecting its own chairman. The governor shall designate the chairman of the entire Board. Each member of the Board shall be paid a salary equal to that of circuit judges plus reasonable expenses.

(3) A decision concurred in by any two (2) members of a panel will constitute a decision of the Board unless altered by a majority of the entire Board.

(4) The Board and its panels may hold sessions at any place within the state where necessary and may sue or be sued in any court of this state under existing laws. Unless consented to by the Board, all actions or proceedings against it, or a member in his official capacity, shall be brought in the courts of Franklin County.

(5) Any investigation, inquiry or hearing which the Board is authorized to hold or undertake may be held or undertaken by or before any three (3) member panel, a director or hearing officer acting under the authorization of the Board.

SECTION 9. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) The governor shall appoint a director of the Board who shall have immediate supervision of the employees of the Board, perform such duties as are assigned him, and have complete authority to carry out the administrative functions of the Division of Patients' Compensation. The director shall be an attorney admitted to practice law in Kentucky and who has practiced law for at least three (3) years. He shall keep and be the custodian of the records of the Board, shall annually report the activities of the Board to the governor, and shall devote his full time to the duties of the office. He shall receive a salary to be fixed by the governor.

(2) The governor shall appoint the number of hearing officers authorized by regulation of the Board, each of whom shall be an attorney admitted to practice law in Kentucky who has practiced law for at least three (3) years. These officers, upon the direction of the director of the Board, shall conduct hearings and otherwise supervise the presentation of evidence and perform all other duties assigned to them by the director or the Board except that such hearing officer shall not render final decision, orders or awards. However, such hearing officers may, in receiving the evidence, on behalf of the

Board make such ruling effecting the competency, relevancy and materiality of the evidence about to be presented, and upon motions presented during the taking of evidence as will expedite the preparation of the case.

(3) The Board may at any time recommend the removal of the director or any hearing officer upon filing with the governor a full written statement of its reason for such removal.

SECTION 10. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) The Board shall prepare such rules and regulations as it considers necessary to carry on its work and may make rules not inconsistent with this Act for carrying out the provisions of this Act.

(2) Processes and procedure under this Act shall be as summary and simple as reasonably possible. The Board or any member thereof, for the purpose of this Act, may subpoena witnesses, administer or cause to have administered oaths and examine or cause to have examined such parts of the books and records of the parties to a proceeding as relate to question in dispute.

(3) The Sheriff shall serve all subpoenas of the Board and shall receive the same fee as provided by law for like service in civil actions. Each witness who appears in obedience to such subpoena of the Board shall

receive for attendance the fees and mileage for witnesses in civil cases in the circuit courts.

(4) The circuit court shall, on application of the Board or any member thereof, enforce by proper proceedings the attendance and testimony of witnesses and production examination of books, papers and records.

SECTION 11. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) No proceeding under this Act for compensation for an incident shall be maintained unless a notice of claim shall have been given to the health care professional or institution as soon as practicable after the happening thereof, and unless an application for adjustment of claim for compensation with respect to such incident shall have been made with the Board within one (1) year after the date the injury was first discovered, or in the exercise of reasonable care should have been discovered, provided that such claim shall have been made with the Board within five (5) years from the date on which the incident is said to have occurred. A minor under the full age of six (6) years shall have until his eighth birthday in which to file a claim. This section applies to all persons regardless of minority or other legal disability, and is unaffected by the provisions of KRS 413.170.

SECTION 12. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) If the patient and health care professional or health care institution reach an agreement conforming to the provisions of this Act in regard to compensation, a memorandum of the agreement shall be filed with the Board, and, if approved by it, shall be enforceable as is herein provided for the enforcement of awards by the Board. Nothing herein shall prevent the voluntary payment of compensation, the amounts, and for periods prescribed in this Act without formal agreement, but nothing shall operate as a final settlement except the memorandum of agreement filed with and approved by the Board in accordance with this section. No limitation of time shall begin to run until the date upon which such agreement is filed and approved by the Board.

SECTION 13. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) If the parties fail to reach an agreement in regard to compensation under this Act, either party may make written application to the Board for a hearing in regard to the matter at issue and for a ruling thereon. Such application must be filed within the time set forth in Section 11 herein, or within one (1) year after the cessation of voluntary payments, if any have been made.

(2) As soon as possible after the application has been received, the Board will set the date for a hearing, to be held as soon as practicable, in view of the matter involved, and shall notify the parties at issue of the time and place of such hearing.

(3) Unless otherwise agreed to by the parties and authorized by the panel, the hearing shall be held at or convenient to the place where the injury was sustained or the ground for disagreement occurred. Before directing a hearing, the board, a member thereof, the director or a hearing officer authorized by the board, may confer informally with the parties at issue in an attempt to assist in adjusting their differences, but may not delay the granting of a hearing, over the objection of either party for such purpose.

(4) If the parties have previously filed an agreement which has been approved by the board and compensation has been paid or is due in accordance therewith, and the parties thereafter disagree, either party may invoke the provisions of Section 41 which remedy shall be exclusive.

SECTION 14. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) The board, a panel or any of its members, the director or any hearing officer directed by the Board,

shall hear the parties at issue and their representatives and witnesses, and the panel shall determine the dispute, in a summary manner. The award, order or decision shall be made within thirty (30) days after final submission, except in cases involving large or complicated records or unusual questions of law, and shall be made within sixty (60) days after final submission in any event. However, if the award, order or decision is not rendered within thirty (30) days, the board shall notify the parties in dispute setting out the reasons for such delay. The award, order or decision, together with a statement of the findings of fact, rulings of law and any other matters pertinent to the question at issue, shall be filed with the record of proceedings, and a copy of the award, order or decision shall immediately be sent to the parties in dispute.

SECTION 15. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) Within fourteen (14) days from the date of the award or decision, any party may file a petition for reconsideration of the award, order or decision of the panel. The petition for reconsideration shall be made to the whole board and shall clearly set out the errors relied upon with the reasons and arguments for reconsideration of impending award, order or decision. All other parties shall have ten (10) days thereafter to

file a response to the petition. The Board shall make the final decision and shall report its decision within ten (10) days after submission.

SECTION 16. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) An award or order of the board as provided in Section 14, if petition for reconsideration is not filed as provided for in Section 15, shall be conclusive and binding as to all questions of fact, but either party may within twenty (20) days after the rendition of such final award or order of the board, by petition appeal to the circuit court that would have jurisdiction to try an action for damages for the injuries if this Act did not exist, for the review of such order or award, the board and the adverse party being made respondents. The board shall be named respondent as the patients' compensation board, and service shall be made on the director.

(2) The petition shall state fully the grounds upon which a review is sought, and assign all errors relied on. Summons shall issue upon the petition directing the adverse party to file an answer and cross-appeal, if appropriate, within twenty (20) days after service thereof and directing the board to send its entire original record, properly bound, to the clerk of the circuit court, after certifying that such record is its entire original

record, which shall be filed by the clerk of the circuit court and such record shall then become and be considered by the circuit court on the review.

(3) No new or additional evidence may be introduced in the circuit court except as to the fraud or misconduct of some person engaged in the administration of this Act and affecting the order, ruling or award, but the court shall otherwise hear the cause upon the record as certified by the board and shall dispose of the cause in summary manner. The court shall not substitute its judgment for that of the board as to the weight of evidence on questions of fact, its review being limited to determining whether or not:

(a) The board acted without or in excess of its powers;

(b) The order, decision, or award was procured by fraud;

(c) The order, decision, or award is not in conformity to the provisions of this Act;

(d) The order, decision, or award is clearly erroneous on the basis of the reliable, probative, and material evidence contained in the whole record; or

(e) The order, decision, or award is arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion.

(4) The board and each party may appear in such review proceedings; the court shall enter judgment affirming, modifying or setting aside the order, decision or award, or in its discretion remanding the cause to the board for further proceedings in conformity with the direction of the court. The court may, before judgment and upon a sufficient showing of fact, remand the cause to the board.

(5) The appeal shall be advanced on the circuit court docket without motion or notice.

SECTION 17. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) The judgment of the circuit court shall be subject to appeal to the Court of Appeals. The scope of review by the Court of Appeals shall include all matters subject to review by the circuit court and also errors of law arising in the circuit court and upon appeal made reviewable by the Rules of Civil Procedure where not in conflict with this Act.

(2) The procedure as to appeal to the Court of Appeals shall be the same as in civil actions, so far as it is applicable to and not in conflict with this Act.

(3) The appeal shall be advanced on the Court of Appeals docket without motion or notice.

SECTION 18. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) Any party in interest may file in the circuit court of the county in which the injury occurred a certified copy of a memorandum of agreement approved by the board or of an order or decision of the board, or of an award of the board on appeal from, or an award of the board rendered upon an appeal whether or not there is a motion to reopen or review pending under Section 41. The court shall render judgment in accordance therewith and notify the parties. Such judgment shall have the same effect, and all proceedings in relation thereto shall thereafter be the same as though it had been rendered in a suit duly heard and determined by that court. Any such judgment, unappealed from or affirmed on appeal or modified in obedience to the mandate of the Court of Appeals shall be modified to conform to any decision of the board ending, diminishing or increasing any weekly payment under the provisions of Section 41 upon a presentation to it of a certified copy of such decision.

SECTION 19. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) The board, or any member thereof, may, upon the application of either party or upon its own motion, appoint not more than three (3) disinterested and duly

qualified physicians or surgeons to make any necessary medical examination of the patient and to testify in respect thereto. Such physicians or surgeons shall file with the board within fifteen (15) days after such examination their joint report in writing. The physicians or surgeons shall be allowed a reasonable fee to be fixed by the board and paid out of the maintenance fund, not exceeding seventy-five dollars ($75.00) for each examination and report, except that the board may allow additional reasonable amounts in extraordinary cases and the reasonable cost of X-rays, if any; the board may in its discretion allow a fee not in excess of twenty-five dollars ($25.00) for any deposition given by such physicians or surgeons.

(2) The party filing the motion for an examination shall pay the necessary and reasonable traveling expenses incurred by the employe in submitting to such examination. If the examination is ordered on the board's own motion, then such traveling expenses shall be paid out of the budget of the board.

SECTION 20. A NEW SECTION OF KRS CHAPTER 311A IS CREATED TO READ AS FOLLOWS:

(1) In addition to all other compensation provided in this Act, the health care professional or institution shall pay for the cure and relief from the effects of an