

ALASKA LEGISLATURE COMMITTEE FILES, 2003-2004

10861 HOUSE JUDICIARY

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ORDERED, ADJUDGED AND DECREED this 22 day of August, 1996 at Anchorage, Alaska.

B Shortell
Brian C. Shortell
SUPERIOR COURT JUDGE

Received this 15 day of Aug, 1996 at 4:15 a.m./p.m.

MALONEY & HAGGART
Attorneys for Plaintiff
[Signature]
Dennis Maloney

I certify that on 8/22/96
a copy of the above was mailed to each
of the following at their addresses of
record: Meloney/Holmes
[Signature]
Secretary/Deputy Clerk

CFS/dlj;pldg judgment.doc

Date 10-7-96
-u: Clapp, Peterson & Stowers

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA
THIRD JUDICIAL DISTRICT

BARRY VINCENT JOHNSON,)
)
 Plaintiff,)
)
 vs.)
)
 DOUGLAS C. SMITH, M.D. and)
 KATHLEEN FIELDS,)
)
 Defendants.)

FILED IN THE TRIAL COURTS
State of Alaska Third District

OCT 07 1996

Clerk of the Trial Courts

By [Signature] Deputy

Case No. 3AN-93-02919 Civil

ORDER

Defendants' motion for attorneys' fees is GRANTED. Defendants are awarded \$15,846.45 pursuant to Civil Rule 821(b)(2). This figure has been added to the final judgment.

DONE this 7th day of October, 1996, at Anchorage, Alaska.

[Signature]

BRIAN SHORTELL
Superior Court Judge
Third Judicial District

I certify that on 10/8/96
a copy of the above was mailed to each
of the following at their addresses of
record: Stowers / Maloney
[Signature]
Secretary/Deputy Clerk

Exhibit A
Page 12 of 13

Subject: HB 472 names

Date: Tue, 24 Feb 2004 15:00:23 -0900

From: Jeff Logan <jefflogan@gci.net>

To: vanessa_tondini@legis.state.ak.us, josh_applebee@legis.state.ak.us

Vanessa,

The list of people who want to testify on HB 472 tomorrow:

In person:

Jim Jordan, Executive Director, Alaska State Medical Assn.

Dr. Alex Malter, President, Alaska State Medical Assn.

Mike Haugen, Executive Director, Alaska Physicians and Surgeons.

On Teleconference:

Dr. George Rhyneer, Alaska Heart Institute

Dr. John Duddy, President, Alaska Physicians and Surgeons

Dr. Mark Withrow, Kodiak Island Clinic

Dr. Richard Cobden, Tanana Valley Clinic

Ron Neupauer, MIEC (Medical Indemnity Exchange of California)

There you have it.

JL

HB

472

(File 2 of 7)

**2004 ALASKA
MEDICAL LIABILITY
REFORM**

State &

Local

Material

Why Medical Liability Reform is Important

- Alaska's medical liability system is breaking down, which will have a direct affect on patient access to physicians.
- During the last year, the Alaska marketplace for professional liability insurance for physicians shrank to 2 doctor owned and operated insurers – MIEC and Norcal.
- Both MIEC and Norcal have initiated changes in their rate structure in the last two years that have significantly increased physician professional liability insurance premiums in Alaska.
- Other professional liability insurance insurers have not shown interest in conducting business in Alaska.
- Why is this important to Alaskans?
 - Alaska relies on attracting physicians from the rest of the country. We have no medical school.
 - Alaska reportedly has one of the fewest numbers of physicians per capita in the country and arguably has the fewest.
 - Providence Hospital released a study in the fall of 2002 that showed Anchorage is short 200 full time equivalent physicians with critical shortages in specialties such as, general internal medicine, psychiatry and ENT.
 - The Alaska State Medical Society has indicated the physician workforce is rapidly aging with over half the physicians over the age of 50.
 - A huge and imminent recruiting effort is necessary to insure that Alaska has sufficient numbers of well-trained doctors.
 - A practice environment that is conducive to attracting well-trained physicians in sufficient numbers is essential to adequate health care for Alaskans.
 - The professional liability environment is key to a good practice environment.
 - Insurance availability
 - Insurance affordability
 - In other words, attracting and keeping adequate numbers of physicians in Alaska requires available and affordable malpractice coverage.
 - Costs for professional liability insurance premiums affect the cost of health care. Those costs directly impact the payment rates for both Medicare and Medicaid.

Alaska's 1997 Liability Reform addressed many of the problem areas, but did not sufficiently address caps on non-economic damages (e.g. pain and suffering).

Current caps allow for pain and suffering awards to reach almost \$2,000,000.

The standard that has been set in California (under MICRA) is \$250,000 and is the gold standard sought in numerous states and in the federal reform measures.

A \$250,000 cap on non-economic damages will have the most significant impact on professional liability rates and will help to attract other insurers into the Alaska market place.

Instituting a \$250,000 cap on non-economic damages will help stabilize professional liability rates.

Instituting a \$250,000 cap on non-economic damages will help create a practice environment that will help recruit the doctors that we need.

Instituting a \$250,000 cap on non-economic damages will help temper the increases in federal and state budgets for Medicare and Medicaid.

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Shingle Shortage!

State statistics point to a coming medical crunch as aging doctors retire

By ANN POTEPIPA
Anchorage Daily News

One of the youngest states in the nation has an aging problem: Its doctors are growing older. Jim Jordan, executive director of the Alaska State Medical Association, wanted to know just how old Alaska's doctors had become. His staff studied a list of physicians and guessed their ages from the dates they graduated from medical school. Based on his study, about half are older than 50.

His guess was right. Leslie Gallant, executive administrator of the state medical board, verified Jordan's research with her own database, complete with ages. Today, 48 percent of Alaska's licensed doctors have passed the half-century mark.

Gallant's data shows a sharp drop-off in practicing physicians as the decades mount up: Almost 650 retain their licenses in their 50s, but less than half that many remain licensed into their 60s. Slightly more than 100 of the state's 2,170 doctors are 70 or older.

That statistic foreshadows a pending crisis.

"Within the next 10 years, we could lose as many as half of Alaska's doctors," said Dr. Harold Johnston, a family practice physician who's older than 50.

When these doctors retire or cut back their practices, more doctors will have to move here and fill in. But that's not happening.

"They're not coming to Alaska," Johnston said.

At least not with the frequency they did in the past.

"There's going to be a problem, and we see it coming," said Dr. Tom Nighswander, who turns 60 this year. "And the time to be working on it is now."

Doctors used to come to Alaska for many reasons. Physicians came here to flee states that had health

MAINTENANCE ORGANIZATIONS

66

There's going to be a problem, and we see it coming. And the time to be working on it is now.

99

— Dr. Tom Nighswander

maintenance organizations.

"They were what I termed to be 'managed care refugees,'" Jordan said.

But Johnston said managed care is changing, and fewer doctors are moving here for that reason now.

Decades ago, the government signed up doctors to come north and work with the military and the U.S. Public Health Service. In the early 1970s, Nighswander came to Alaska to fulfill a two-year contract with the U.S. Public Health Service.

"That is where the Indian Health Service got all their manpower," he said.

Thirty years later, he's still here. Other physicians who came to Alaska through the health service finished their contracts and elected to stay, too.

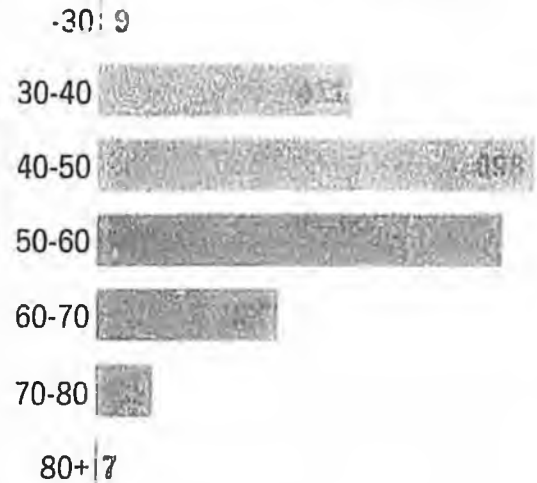
Nighswander said the public health service's role in Alaska has changed since those days. It no longer brings doctors to Alaska to serve the Native population. Instead, the tribes have taken over and directly recruit their own physicians to care for Alaska

See Page E-2, DOCTORS

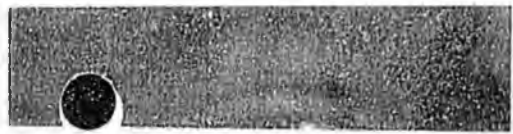
ALASKA'S AGING PHYSICIANS

State officials are concerned about Alaska's ability to serve the medical needs of residents as the state's physicians get older. Records show a sharp drop in the state's number of physicians who continue to practice beyond the age of 60. Almost half the state's licensed physicians are more than 50 years old.

Age group Number of licensed physicians



Source: Alaska State Medical Board 2002



Contact allows some blind to see

UNKNOWN: Few have

"I was standing at the end of the

trated. Today, eight years

DOCTORS: State may face shortage

Continued from E-1

Natives, he said. That means tribes recruit doctors just like any other private health care provider in town.

Some factors will always threaten Alaska's recruitment efforts. Some doctors don't like the weather here; others find the state too remote and far from family.

"We're a long way from anywhere," Jordan said. "Until people come up here and visit, they think that we're at the other end of the world."

Dr. Gerald Morris, a retired internist, said it's always been a little difficult to recruit doctors here unless they were people who enjoyed the outdoors.

Certain specialties are harder to recruit than others. The state medical association's records identifies only three rheumatologists in Alaska, doctors who specialize in treating arthritis and similar ailments. All of them are older than 60, according to Gallant's database.

"We badly need internists in town," said Dr. Keith Brownsberger, a long-time internist. "It's very, very slim right now."

Brownsberger is 69 years old and has been practicing medicine in Alaska for more than 30 years. He said he feels like he needs to stay in practice to take care of his patients.

"I will never abandon my patients, unless I get sick," he said.

Fellow internists say they struggle to find partners who'll help manage the workload. Morris and a former colleague, Dr. Michele O'Fallon, tried to recruit partners to augment their practice at Anchorage Community Internists, a clinic that dissolved last week.

"I tried for years to get somebody up here to practice rheumatology with me and to assist the community in that subspecialty," Morris said.

"I didn't even get a nibble."

Urusan opened a new clinic today. She and Dr. Jeanne Bonar, an internist older than 50, have encountered legal problems when trying to recruit physicians. Both advertised for partners, but the few responses that came in were from foreign doctors with visas. The law allows doctors with visas to stay in the country so long as they work in medically underserved areas, the doctors said. Neither O'Fallon nor Bonar work in such an area, even though they said underserved areas aren't far away. O'Fallon finally found a new partner; the doctor grew up in Alaska and wanted to return, she said.

O'Fallon wrote to U.S. Sen. Ted Stevens this spring to explain the recruitment problems.

"This is the pattern for many medical practices in Anchorage," she wrote. "The physicians in this community have become overwhelmed and exhausted."

"Anchorage, and the state



Dr. Keith Brownsberger, 69, has been a general practitioner in Anchorage for more than 30 years.

as a whole, is on the verge of a medical crisis."

Recruitments become more difficult as primary care doctors, such as internists, are making less money than specialists, local internists say. In addition, doctors in general say they make less and less money on Medicare patients because the federal government is decreasing the Medicare reimbursement rate.

"More and more physicians are not going into primary care because it doesn't pay," O'Fallon said. "So the physician shortage is just getting worse and worse."

Doctors shared possible solutions, including trying to get the government to improve Medicare's reimbursement rates. Johnston said the number of Alaskans admitted every year to the WWAMI medical school program could be increased if the state approved more funding. WWAMI provides medical educations to students from Washington, Wyoming, Alaska, Montana and Idaho.

He also talked about the possibility of increasing the number of medical residents in the state's only residency program for family practice doctors.

O'Fallon said she thought the state government should consider providing incentives to recruit physicians to Alaska

and possibly subsidize the new physicians' salaries until they become productive.

"We're going to have to be a net importer of physicians," Nighswander said.

Doctors might be enticed to move here if the state came up with different ways to practice medicine, he said.

"I work with a lot of young physicians, and they are not willing to work the hours that we did in the past," he said. "And they're probably smart."

One alternative might be flex time, he said, allowing doctors to work different shifts, such as working 40 hours in four days.

Fixing the problem won't happen quickly, Jordan said. Assuming that half of Alaska's doctors retire in 10 years, Jordan warned it could take at least that long to create a new crop of incoming physicians. To become a doctor, a high school graduate must finish four years of undergraduate study, then four years of medical school and finally a residency that could take three more years, he added.

"It's not like you can turn the switch and say, 'We need more doctors tomorrow' and it's going to happen," Jordan said. "There's a long lead said that's needed."

Reporter Ann Potempa can be reached at spotempa@edna.com.

Get the newspaper,

Anchorage Daily News

not the bill.

Study casts doubts

November 6, 2003

Alaska policyholders update – renewal 2004

Rate increase

The Alaska Division of Insurance has approved recommendations from our consulting actuaries for the following rate changes, which will apply upon renewal of your coverage February 1, 2004:

- A 5% base rate increase for all physician and non-physician employee classes.
- Premium for separate medical corporation and partnership policies will increase from 7.5% to 10% of individual physician members and employed doctors premium.
- Neurologists and neonatologists will be reclassified into higher-rated categories, with increases of 20% and 8.7%, respectively.
- Policyholders who purchase \$2/4 million or higher limits of liability will experience higher charges for the excess portion of the rate, ranging from 10% to 22%, depending on specialty and rate classification.

Normal claims-made step rate increases will apply to policyholders insured for less than five years. New to practice discounts will continue to apply for the first three years of practice.

The rate increase is needed because claims severity (the *average* cost to defend malpractice claims reported by our Alaska policyholders and to settle a small percentage of them) has risen in the last few years. At the same time, the investment income MIEC earns, which is used to offset rates, is lower due to declining interest rates on bonds, which comprise the majority of MIEC's investment portfolio.

With this increase, MIEC's Alaska rates will be at about half their 1992 levels, while over the same period, the Consumer Price Index rose by 58%. MIEC also returned \$23.1 million in dividend credits to Alaska policyholders between 1991 and 2001.

What's driving up the costs of claims?

Almost 90% of claims reported by MIEC's policyholders result in no payment of indemnity to plaintiffs. That statistic hasn't changed much over the years and serves as the best evidence of just how dysfunctional the medical tort system has become. However, in the 10% of cases that are settled or tried to a plaintiff verdict, the average costs of indemnity and legal defense rose from \$138,676 on claims closed between 1991 and 1996, to \$289,153 for claims closed in the latest six years.

We think there are several causes:

- Juries are sympathetic to severely injured plaintiffs, regardless of whether the defendant(s) medical care caused or contributed to their injuries.
- Catastrophically injured plaintiffs require sophisticated, round-the-clock care – economic damages that are not limited by Alaska's cap on pain and suffering loss. Experts testify in court that such care will be prohibitively expensive in future decades. Even when future damages are reduced to present value and we pay them in installments by purchase of annuities, the present value can run into many millions of dollars.
- The complex technology of today's medicine, with stretched and diminishing resources of medical care, creates a dangerous environment for physicians, hospitals and other health care providers. Well-known capabilities of modern medicine create expectations of perfection, so that when a catastrophic outcome occurs, some people readily believe it is due to negligence. They want compensation for their injury and loss. The hugely expensive, adversarial lawsuit industry results.
- New theories of liability and new legal arguments intended to wrest settlements or larger verdicts have become common. Some arise from medical procedures or drugs alleged to be harmful. Some spring from exploitation of well-intended legislation to protect against elder abuse or prevent unwarranted transfer of patients from one hospital to another for financial reasons. These cases carry the threat of punitive damages or include allegations of fraud or intentional harm, which often are not covered by malpractice insurance if proven. The mere assertion of such claims places the defendant doctor at odds with the insurer which often leads to settlement of cases in which no actual liability exists. Medical liability has become a growth industry that hugely benefits a small number of opportunistic lawyers.

What can be done to slow this trend?

MIEC supports the Alaska State Medical Association's continuing efforts to maintain and strengthen Alaska tort reforms. Savings in claims costs that result from tort reforms or other factors belong to MIEC's policyholder-owners. MIEC will maintain its longstanding policy of returning monies not needed for claims or administrative expenses to policyholders as dividend credits. Future rate levels will reflect changes in claims frequency and severity.

As a policyholder-owned and governed company, MIEC seeks no profit from the insurance business. By law and by prudent fiscal practice, we establish rates sufficient to cover the expected costs of claims, legal defense and operating costs in the coming year. In past years, when MIEC made a profit, it was either returned to policyholders as credits against renewal premiums or used to strengthen the financial cushion for all policyholders. Results in more recent years have been unprofitable, meaning the additional dividend credits are unlikely in the next few years.

We support additional tort reforms to stabilize rates in the long term, and to remove the inequities from the litigation lottery system that now prevails. These include:

- A sliding scale limitation on plaintiff attorney contingent fees. This would ensure that the injured plaintiff gets the benefit of the award, not the attorney.
- Admission into evidence during trial of all collateral sources of payment for medical or other claimed expenses. This eliminates duplicate recovery for the same claimed economic loss. Third party payers must be prevented from asserting cross-claims for indemnification.

We also believe that more fundamental change in the current adversarial, fault-based litigation system will be required to bring a semblance of predictability and fairness back.

1. **Bifurcation of trials and limitation of contingent fees:** In cases involving permanent, severe injury, or when plaintiffs claim future economic damages in excess of \$1,000,000, change the law so that a jury determines liability but does not assess damages. If the jury finds liability, a panel of court-appointed experts would determine the amount and stream of indemnity payments required to compensate for injury and ensure maximum benefit to plaintiffs, consistent with preservation of scarce health care funds. The panel would be empowered to determine plaintiff attorney fees, based on actual hours of services performed instead of a percentage of the indemnity awarded. Contingent fees for damages less than \$1,000,000 would be limited on a sliding scale, under which fees would be capped at 10% of any indemnity in excess of \$500,000.
2. **Certificate of Merit:** Require that prior to filing a malpractice suit, a Certificate of Merit must be signed by one or more Board certified physicians who have reviewed the facts of the case. Physicians signing a Certificate of Merit must have current clinical or faculty practice in the same specialty as a defendant to be named in a malpractice suit. The law should provide sanctions against physicians and attorneys signing or filing false statements, or statements signed without conducting prior review of available medical records.
3. **Disclosure of structured settlement offers:** Require plaintiff attorneys to disclose to their client offers of structured settlements, including the amount of attorney fees involved in such offers. Require a copy of such disclosure be given to the defendant(s).
4. **Birth injury funding mechanism:** Establish a "modified no-fault" system for funding catastrophic birth injuries that require a lifetime of specialized care, including educational, occupational, mobility, as well as medical needs. This would involve establishment of a permanent trust fund with third party administration, as in the Virginia model, but with modifications. All obstetricians and others who deliver babies would fund it, as would hospitals, birthing centers and other facilities. Plaintiff attorneys would not be paid from funds in the birth injury trust fund. They would receive hourly compensation for services rendered as outlined in (1) above.

What else can be done?

Studies have shown that relatively simple changes in some procedures, clear communication among health care professionals, and prompt, accurate record entries, prevent misunderstandings that can lead to disastrous outcomes in care. Technology can help and resources are available. MIEC participates in the effort through its many loss prevention initiatives which we believe reduce litigation severity and frequency. We also vigorously support all organizations that join us in efforts to end the many abuses that a small number of lawyers have imposed on our legal system.

Every practitioner has an interest in accomplishing this for the benefit of patients. The public and the legislature rightly expect this commitment from medicine. The effort can and should come from medicine instead of being imposed by ever more intrusive regulation and bureaucracy.

MIEC appreciates your continued support and loyalty for our professional liability program. We will continue to work with the Alaska State Medical Association and with each of you to reverse the current trend in malpractice litigation costs.



Ron Neupauer
Vice President
Medical Underwriters of California

MIEC Contacts:

Lauren Kielian
Underwriting Manager

Diane Major
Assistant Underwriting Manager

Karen Tuttle
Underwriter



Northwest Physicians Mutual Insurance Company

765 Ryan Drive S.E. • Salem, Oregon 97301-5074 • (503) 371-8228 • toll-free 1-800-243-3503
.O. Box 13400 • Salem, Oregon 97309-1400 • FAX (503) 371-0087 • www.npmic.com

January 27, 2004

George S. Rhyneer, M.D., Director
Alaska Physicians and Surgeons
4120 Laurel, #206
Anchorage, Alaska 99508

RE: Regulatory and Legal Climate in Alaska

Dear Dr. Rhyneer:

In 2003, Northwest Physicians Mutual Insurance Company (NPM) discontinued insuring physicians in Alaska. The Company discontinued insuring physicians in Alaska because it could not get the Alaska Insurance Department to approve the actuarially supported and needed rate increases. It was with great reluctance that NPM discontinued insuring Alaska physicians. As a physician owned mutual insurance company, NPM must have the ability to charge the appropriate rates in order to continue in business.

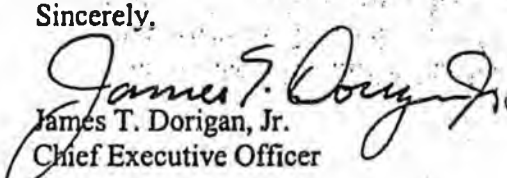
As you know, there is a medical malpractice insurance crisis in this country. National insurance companies such as St. Paul and Farmers have discontinued providing malpractice insurance nationally. The crisis is driven by claims severity and the unpredictability of large settlements and verdicts. In recent years, companies have lost a great deal of money and have responded by withdrawing entirely from providing medical malpractice insurance or have concentrated in states that have a favorable environment including broad based tort reform.

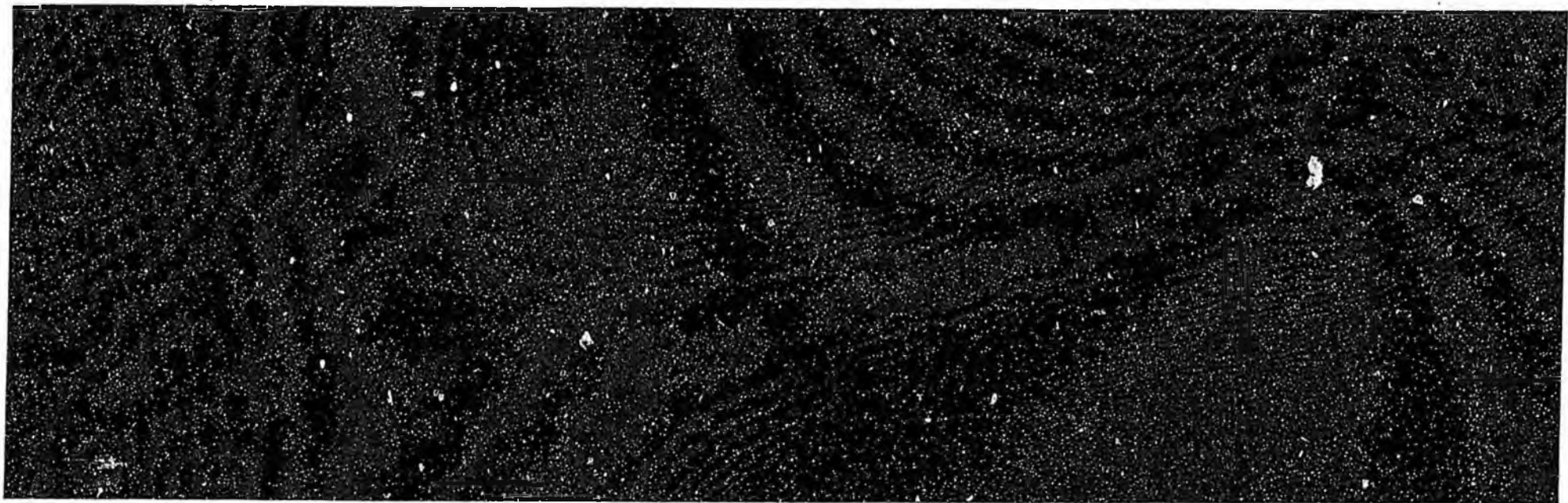
NPM's claims experience in Alaska was sufficiently negative that it supported rate increases well over 100%. The experience in Alaska in general has deteriorated over the last several years. Alaska has in place several tort reform measures, which provide some relief, but in order to stabilize the Alaska market and attract additional insurance companies, I feel that a comprehensive tort reform package would be of major benefit. The states that have demonstrated the highest degree of market stability have a tort reform package, which includes a \$250,000 cap on non-economic damage. The model legislation is the MICRA legislation that has been in effect in California since 1975. This is also the same package of reforms, which were passed by the US House of Representatives in 2003 but failed to pass in the Senate.

Rather than waiting for help at the federal level, I would encourage you to work with the Alaska state legislature to pass reforms at the state level.

Please let me know if I can be of additional assistance or provide additional information.

Sincerely,


James T. Dorigan, Jr.
Chief Executive Officer



Fall, 2002



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Objective of Project and Presentation:

The Providence Health System Area Board has once again directed the Administration to conduct a physician needs assessment for the Anchorage community. The assessment is intended to be used for the following:

- Understand current and future physician needs for the Anchorage community
- Provide detailed information which may be utilized by medical staff in their recruiting efforts
- Aid in the Health System's assessment of the physician gaps in our provision of services
- Aid in the assessment of the need for additional office space on the Providence campus
- Considered in other strategic planning

Steering Committee Team Members:

The administrative team involved in the production of the data used in this report includes the following:

- Aron Wolf, M.D., MMM
Rural Administrator
- Barbara Symmes
Co-director of PHSA Planning
- Lisa Wolf
Co-director of PHSA Planning
- Susan Humphrey-Barnet
Assistant Administrator
- Del Bailey
Assistant Administrator

Sources used in the Analysis

Data from several sources was used in the analysis of physician needs for the Anchorage community. Those sources include:

- The 1998 and 2000 Physician Needs Assessment
- Practice Manager Survey
- 55 and Older Physicians Survey
- National physician/population ratios
- Local, historic physician/population ratios
- National population projections
- Local population projections
- Other national and local census statistics
- Medical Group Management Association (MGMA) production survey
- Merritt, Hawkins, & Associates (1999) "Excellence in Physician Search"
- Arthur Andersen Healthcare Consulting
Thomas W. Evert (Partner)
- University of Alaska Anchorage Institute for Circumpolar Health Studies
Brian Saylor, Ph.D, MPH (Director)
Sanna Doucette
Rebecca Nichols

Approach:

The Steering Committee decided to approach this project on the following three levels:

Internal Team Analysis: The involvement of the internal team consisted of the following data collection efforts and other analysis including:

- Accumulate demographic data about the Anchorage and Alaska market
- Amass physician availability data in Anchorage
- Amass physician availability data at Providence
- Compare data by specialty against national norm studies
- Compare this data with the 2 earlier studies

Local Market Survey: The Institute for Circumpolar Health Studies was retained to do two surveys of present physicians. One survey was for physicians ages 55 and older to determine their length of time to remain in practice. The other was to the office managers of physician practices in the Anchorage area. These surveys were geared at assessing both recruiting and perceptions of underserved specialties.

External Consulting Services: The Institute for Circumpolar Health Studies was retained to provide

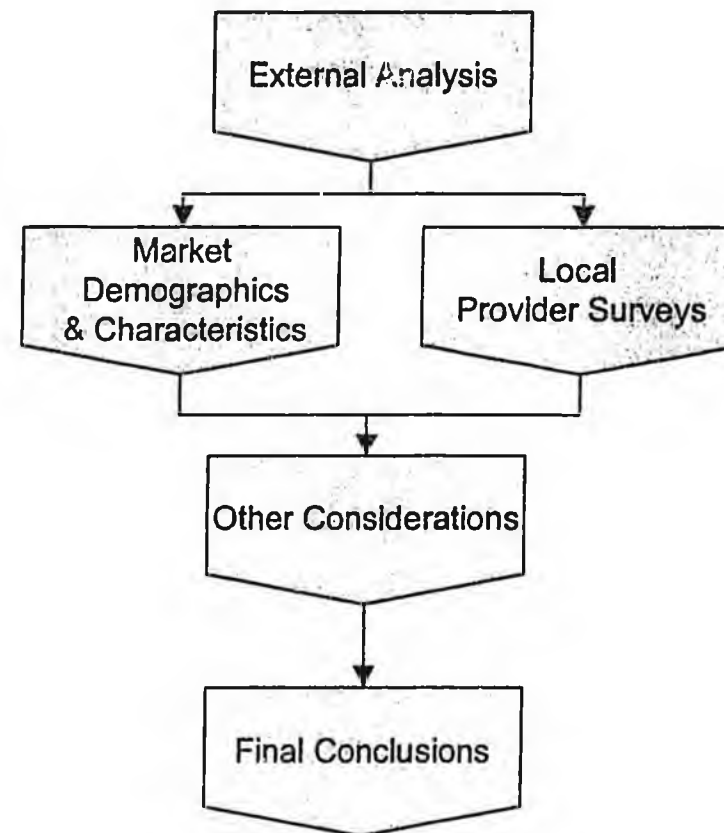
- Comparisons against national data
- Synthesis of overall project results
- Presentation support

Methodology:

Data made available was synthesized, analyzed, and included in the following:

- **External Analysis:** A provider comparison of the Anchorage medical community with US average.
- **Unique Market Demographic/Characteristics:** A demographic comparison of Alaska and the US as well as the exclusion of certain populations being served by various aspects of the Federal Government.
- **Results of Local Surveys:** A description of the results of the two surveys performed by the Institute for Circumpolar Studies and Providence Hospital. Supplemental information from other surveyed providers and or comparative data has also been reported.
- **Other Considerations:** A list of other dynamics that may influence the need for provider services.
- **Final Conclusions:** Summary of findings and conclusions.

Methodology Model





Data Reviewed and Utilized:

There exist many sources that estimate the need for medical providers based on a community's population. We have reviewed the following:

- The Physician Executive Physician Need Rates article
- The Pew Health Care Professors Commission
- Intellimed Inc. National Data results
- Medical Economics Physician Need Rates
- American Medical Association (AMA) Physician Need Rates
- GMENAC Physician Need Rates
- Merritt, Hawkins, & Associates Excellence in Physician Search

After reviewing the above mentioned data we have determined to use as a baseline Merritt, Hawkins, & Associates (1999) "Excellence in Physician Search." This document projects the number of physician FTEs needed by specialty per 100,000 persons as a U.S. average. This data when compared to other data sources proves to be generally consistent, following the likely trends expected by physician needs in a community. Anchorage physicians/population relationships which are significantly different than national averages will be specifically addressed within the body of this presentation.

Population Estimation:

To enable a comparison of the physicians in the Anchorage community with the U.S. national average benchmarks and other data, it was necessary to estimate more specifically the population in need of care in the private sector. Listed below and to the right are the sources of population data used in the 1998 study and represent to some extent the assumptions made to determine logical physician/population figures. The population projections for the 2000 study and now the 2002 study are based upon the original 1998 population estimates adjusted by the projected population growth rates from the State of Alaska.

To estimate the potential primary care patient population in Anchorage, the 2000 estimate was increased by 4.9% resulting in the 2002 estimate of 269,567.

The population for the specialists was determined by the composite statewide figure of potential specialty care patients from the 2000 report with a 2/3 addition at the Anchorage growth rate of 4.9% and a 1/3 addition at the statewide growth rate of 2.26%. The resulting 2002 estimate of potential specialty care patients is 393,300.

Total Population by Locality:

- Alaska Dept. of Labor, Research & Analysis, Demographics Unit "Alaska Population Projection"

Native Population

- US Bureau of the Census "Alaska Native/Native American Population, Revised 4-29-97"
- Alaska Native Medical Center, native population by community
- 81-85% of native are excluded from the target population based on the ratio of native admissions at Providence compared to the Alaska Native Medical Center

Military Population

- Elmendorf AFB, Director for Personnel and Administration "Alaska Military Services Population" September 30, 1996 (Revised 3-24-97)
- 0% growth is assumed through 2000
- 100% of Active Duty personnel are excluded from the target population
- 25% of Military Dependents are excluded from the target population (assumption is that 75% use Providence or Regional)
- 0% of Reserve Forces, Civil Services and Base Exchange employees are excluded from the target population

VA Population

- Anchorage, Fairbanks, Southeast and Alaska Total--VA Administration
- Other Localities--allocated proportionately based on population to equal Alaska total

Out of Service Area Population

- Estimated percent of remaining population that does not utilize Providence and Regional Hospital

Total Physicians in Anchorage Today:

Multiplying national physician/population ratios by the estimated 2002 Anchorage population and the estimated 2008 Anchorage population produces benchmark national average comparisons for Anchorage in 2002 and 2008. The Anchorage physician figures were determined both by the PAMC staff figures and the 2002 Medical Directory of the Alaska State Medical Association. Physicians practicing only in the public sector were not included.

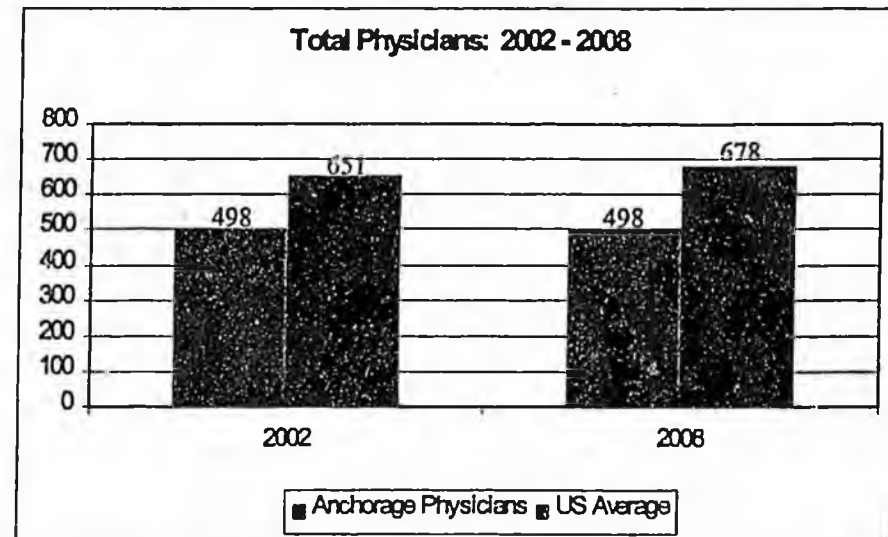
Currently there are 524.85 FTE physicians (after adjusting for time spent practicing) in the Anchorage area. This graphical comparison of the Anchorage physicians with the US average benchmarks includes only 498.05 or 95% of the Anchorage Physicians because only those specialties with 2002 US average benchmarks could be included. The 5% not included are described below the graph.

Based on national physician benchmarks, this represents 153 physicians less than the national average benchmark.

Total Physicians in the Future:

With no change to the 2002 physician complement, it is estimated that physician supply for Anchorage would fall close to 180 physicians below the national average in 2008.

It may be challenging to maintain the current physician levels given anticipated retirements (Section IV).



Primary Care: All were included.

Hospital Based: All were included.

Medical Specialty: Geriatric Medicine (1.75), Oncology/Radiation (1), Pain Management (5), and Sleep (1.6) for a total of 9.35 Anchorage physicians were excluded because there were no 2002 US Benchmarks to compare these specialties.

Pediatric Specialty: Pediatric Pulmonology (1), Pediatric Neurodevelopment (2), and Pediatric Intensive Care (1) for a total of 4 Anchorage physicians were excluded because there were no 2002 US Benchmarks to compare these specialties.

Surgery: Perinatology (2), Hand Surgery (1.75), and Pediatric Surgery (2) for a total of 5.75 Anchorage Physicians were excluded because there were no 2002 US Benchmarks to compare these specialties.

Mental Health: All were included.

Administration: All administrators were excluded because there were no 2002 US Benchmarks to compare these specialties.

Total Physician by Type of Practice:

Currently in Anchorage there are 151.45 primary care providers (including Family Practice, Internal Medicine, and Pediatrics), 92.1 medical providers, 14.75 pediatric providers, 140.5 surgical providers, 92.2 hospital based providers, and 26.15 mental health providers.

Primary care providers are below the national average by a total of 27.55 providers.

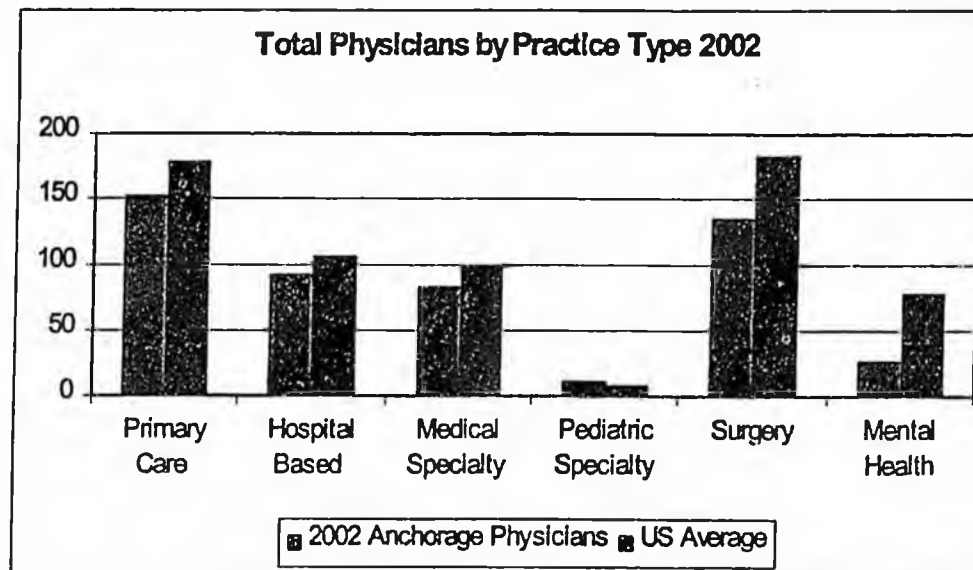
Hospital based providers are below the national average by 12.5 providers.

Medical specialist providers are below the national average by a total of 15.5 providers. There were 9.35 Anchorage medical specialists not included because there were no available US average benchmarks.

Pediatric specialist providers are above the national average by a total of 2.55 providers. There were 4 additional Anchorage pediatric specialists not included because there were no available US average benchmarks.

Surgical specialist providers are below the national average by a total of 48.85 providers. There were 5.75 surgical specialists not included because there were no available US average benchmarks.

Mental Health providers are below the national average by a total of 50.85 providers.



1998 and 2002 Physicians Comparison:

It is of interest to compare the number of Anchorage physicians by practice type in 1998 and 2002. Both the 1998 and 2002 physician numbers were adjusted for the time physicians spend practicing and then rounded to the nearest whole number for this comparison.

Only those specialties with 1998 and 2002 Anchorage physician data were included in this graphical comparison. This graph includes 90% of the 2002 Anchorage Physicians because only those specialties with 1998 comparison data could be included. The 10% not included are described below the graph.

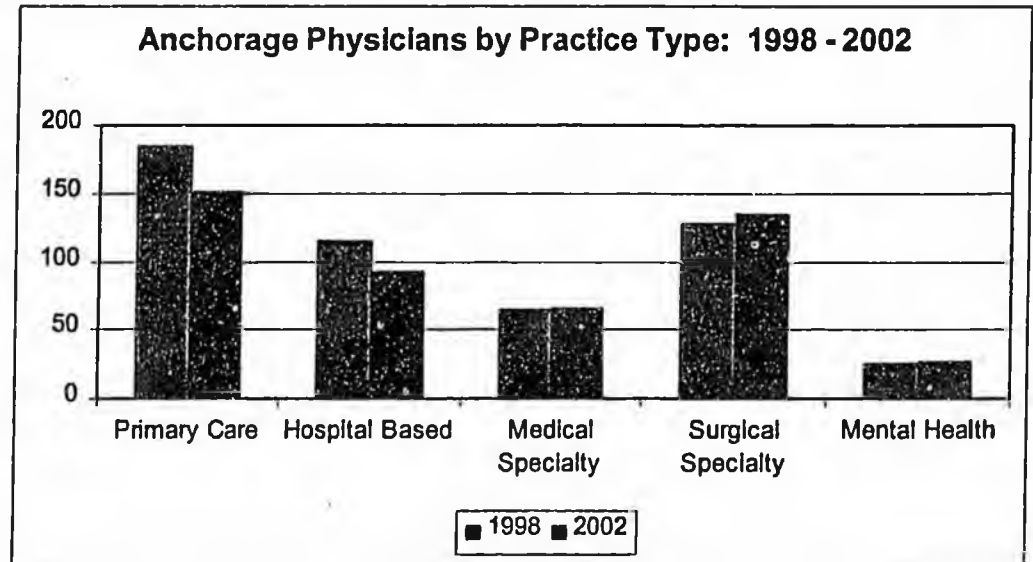
The number of Anchorage primary care providers has dropped from 184 in 1998 to 151 in 2002.

The number of hospital based providers has dropped from 114 in 1998 to 92 in 2002.

The number of medical specialist providers has increased from 64 in 1998 to 66 in 2002. There were 26 additional medical specialists not included because there was no 1998 comparison data available.

The number of surgical specialists has increased from 127 in 1998 to 135 in 2002. There were 6 additional surgical specialists not included because there was no 1998 comparison data available.

The number of mental health providers has increased from 25 in 1998 to 26 in 2002.



Primary Care: All were included.

Hospital Based: All were included.

Medical Specialty: Geriatric Medicine (1.75), Oncology/Radiation (1), Pain Management (5), Physical Medicine/Rehab (14), Preventive Medicine (3), and Sleep (1.6) for a total of 26.35 2002 Anchorage physicians were excluded because there was no 1998 data available.

Pediatric Specialty: All 14.75 2002 Anchorage physicians were excluded because there was no 1998 data available.

Surgery: Perinatology (2), Hand Surgery (1.75), and Pediatric Surgery (2) for a total of 5.75 Anchorage Physicians were excluded because there was no 1998 data available.

Mental Health: All were included.

Administration: All administrators were excluded because there was no 1998 data available.

Primary Care Providers:

Currently in the Anchorage community the following primary care specialties are above the national average benchmark:

- Family Practice

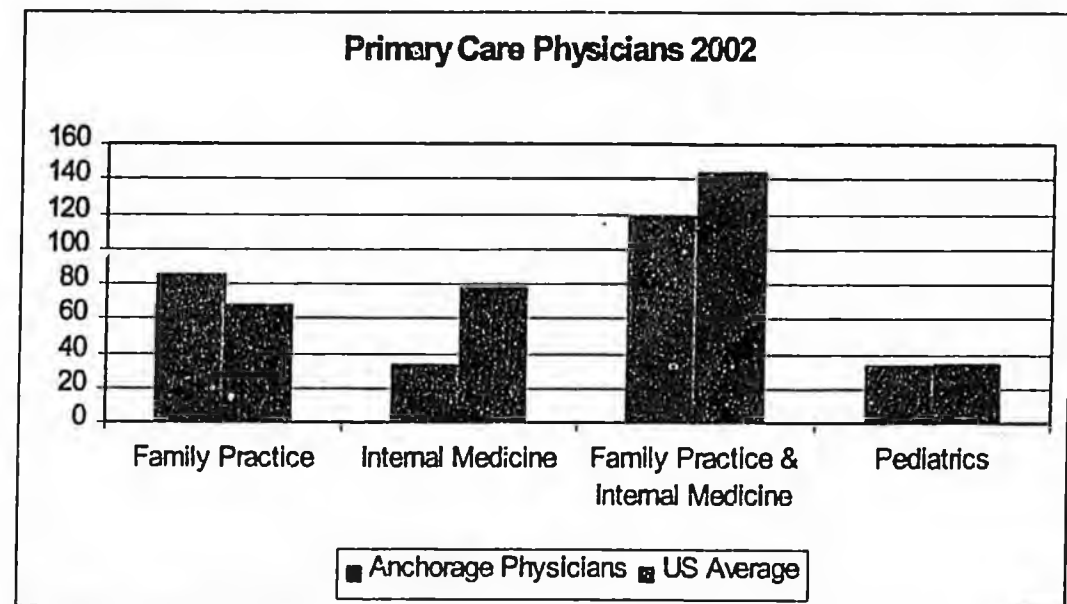
The following primary care specialties fall within the range or have less than a 20% provider deficit when compared to the US average benchmark:

- Pediatrics
- Family Practice & Internal Medicine Combined

The following primary care specialties show a 20% or greater provider deficit when compared to the US national average benchmark:

- General Internal Medicine

What may seem to be a surplus in Family Practitioners may make up for some of the apparent deficit of General Internal Medicine providers. This is why the combined number of family practitioners and internal medicine providers is included in the graph.



Hospital Based Providers:

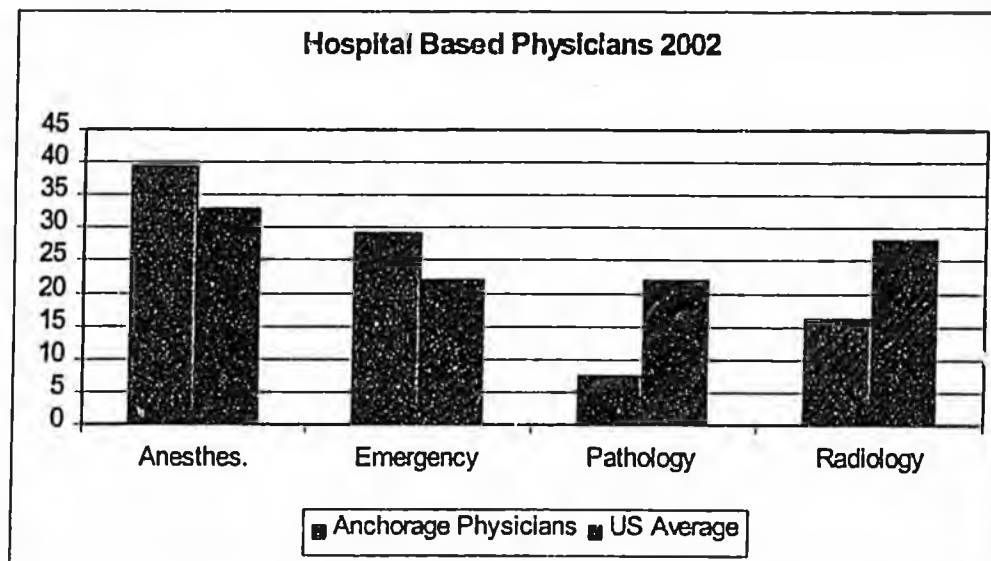
Currently in the Anchorage community the following hospital based specialties are above the national average benchmark:

- Anesthesiologists
- Emergency Medicine

The following hospital based specialties show a 20% or greater provider deficit when compared to the US national average benchmark:

- Pathology
- Radiology

Note: A large number of emergency medicine providers are needed due to Alaska's relatively young population and high number of accidents, as well as the lack of primary care providers.



Medical Specialists:

Currently in the Anchorage community the following medical specialties are above the national average benchmark:

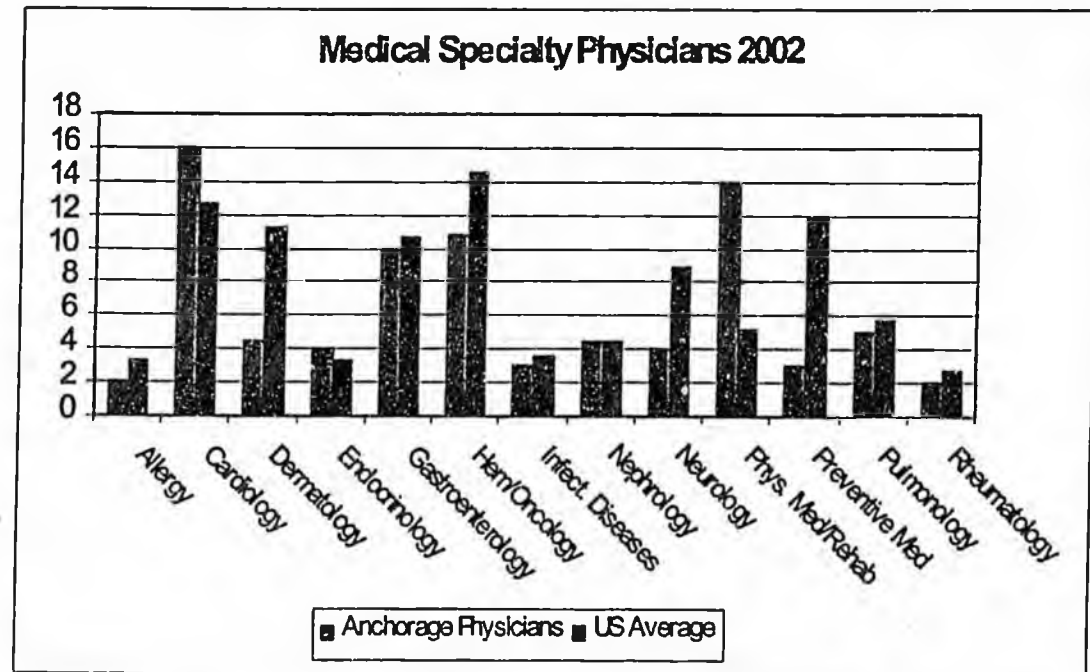
- Cardiology
- Endocrinology
- Nephrology
- Physical Medicine/Rehabilitation

The following medical specialists fall within the range or have less than a 20% provider deficit when compared to the US average benchmark:

- Gastroenterology
- Infectious Diseases
- Pulmonology

The following medical specialties show a 20% or greater provider deficit when compared to the US national average benchmark:

- Allergy / Immunology
- Dermatology
- Hematology/Oncology
- Neurology
- Preventive Medicine
- Rheumatology



The following Anchorage medical specialties were excluded in this graphical comparison because there were no available U.S. Benchmarks:

- Geriatric Medicine (1.75)
- Pain Management (5)
- Sleep (1.6)
- Radiation Oncology (1)

Pediatric Specialists:

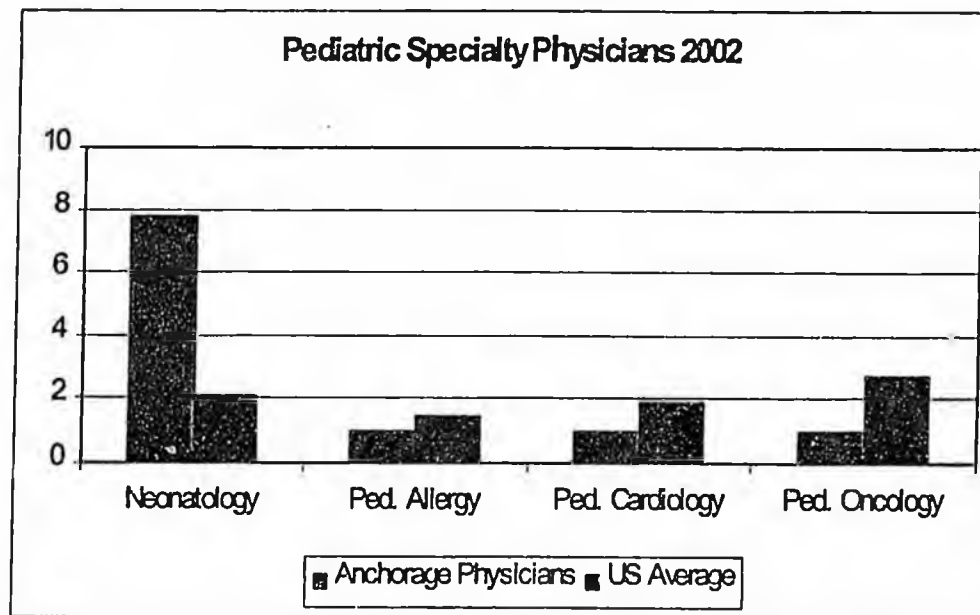
Currently in the Anchorage community the following pediatric specialties are above the national average benchmark:

- Neonatology

The following pediatric specialties show a 20% or greater provider deficit when compared to the US national average benchmark:

- Pediatric Allergy
- Pediatric Cardiology
- Pediatric Oncology

Note: A large number of neonatologists are needed to staff the only level 3 neonatal intensive care unit in Alaska.



The following Anchorage pediatric specialties were excluded in this graphical comparison because there were no available U.S. Benchmarks:

- Pediatric Pulmonology (1)
- Pediatric Neurodevelopment (2)
- Pediatric Intensive Care (1)

Surgical Specialists:

Currently in the Anchorage community the following surgical specialties are above the national average benchmark:

- Cardiac/Thoracic
- Orthopedics
- Plastic Surgery

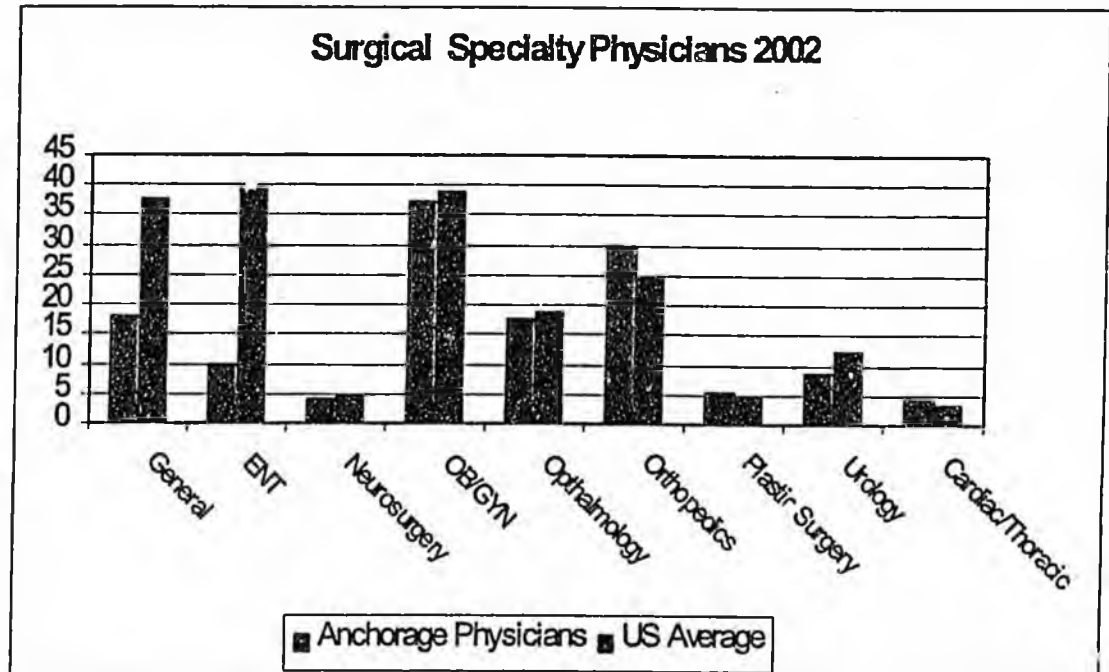
The following surgical specialties fall within the range or have less than a 20% provider deficit when compared to the US average benchmark:

- Neurosurgery
- OB/GYN
- Ophthalmology

The following surgical specialties show a 20% or greater provider deficit when compared to the US national average benchmark:

- General Surgery
- ENT
- Urology

Note: A large number of orthopedics are needed because of the relatively young population and the large number of accidents.



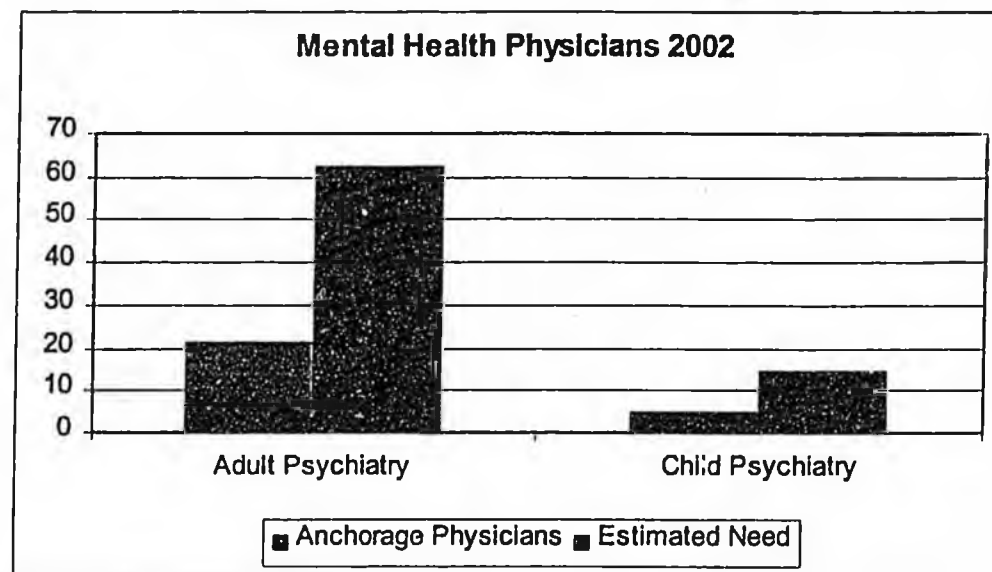
The following Anchorage surgical specialties were excluded in this graphical comparison because there were no available U.S. Benchmarks:

- Hand Surgery (1.75)
- Pediatric Surgery (2)
- Perinatology (2)

Mental Health Providers:

Currently in the Anchorage community the following mental health providers show a 20% or greater provider deficit when compared to the US national average benchmark.

- Adult Psychiatry
- Child Psychiatry



	Number of Anchorage Providers 2002	US Average	Provider Surplus/Deficit	Provider Deficit Percent	Category
Primary Care					
Family Practice	84.45	87.4	17.05	--	above
Internal Medicine	33.75	77	-43.25	56%	> 20% Deficit
*Subtotal (FP & IM)	118.2	144.4	-26.2	18%	< 20% Deficit
Pediatrics	33.25	34.6	-1.35	4%	< 20% Deficit
Primary Care Total	151.45	179	-27.55	15%	< 20% Deficit
Hospital Based					
Anesthesiology	39.5	32.8	6.7	--	above
Emergency	29.2	21.9	7.3	--	above
Pathology	7.5	21.9	-14.4	66%	> 20% Deficit
Radiology	16	28.1	-12.1	43%	> 20% Deficit
Hospital Based Total	92.2	104.7	-12.5	12%	< 20% Deficit
Medical Specialty					
Allergy / Immunology	2	3.3	-1.3	40%	> 20% Deficit
Cardiology	16	12.7	3.3	--	above
Dermatology	4.5	11.2	-6.7	60%	> 20% Deficit
Endocrinology	4	3.3	0.7	--	above
Gastroenterology	10	10.6	-0.6	6%	< 20% Deficit
Hematology/Oncology	10.75	14.6	-3.85	26.40%	> 20% Deficit
Oncology / Radiation	1	--	--	--	--
Infectious Diseases	3	3.6	-0.6	17%	< 20% Deficit
Nephrology	4.5	4.4	0.1	--	above
Neurology	4	8.9	-4.9	55%	> 20% Deficit
Physical Medicine / Rehab	14	5.2	8.8	--	above
Preventive Medicine	3	11.9	-8.9	75%	> 20% Deficit
Pulmonology	5	5.8	-0.8	14%	< 20% Deficit
Rheumatology	2	2.8	-0.8	29%	> 20% Deficit
Geriatric Medicine	1.75	--	--	--	--
Pain Management	5	--	--	--	--
Sleep	1.6	--	--	--	--
Medical Specialty Total	92.1 (82.75)*	98.3	-15.55	16%	< 20% Deficit

*Although there are currently 92.1 medical specialists practicing in Anchorage, 82.75 was for comparison with the US average because there were no available US average benchmarks for the other 9.35 medical specialists.

	Number of Anchorage Providers 2002	US Average	Provider Su. plus/Deficit	Provider Deficit Percent	Category
Pediatric Specialists					
Neonatology	7.75	2.1	5.65	-	above
Pediatric Allergy	1	1.5	-0.5	33%	> 20% Deficit
Pediatric Cardiology	1	1.9	-0.9	47%	> 20% Deficit
Pediatric Oncology	1	2.7	-1.7	63%	> 20% Deficit
Pediatric Pulmonology	1	-	-	-	-
Pediatric Neurodevelopment	2	-	-	-	-
Pediatric Intensive Care	1	-	-	-	-
Pediatric Specialty Total	14.75 (10.75)*	8.2	2.55	-	above
Surgical Specialists					
General Surgery	18	37.8	-19.8	52%	> 20% Deficit
ENT	10	39.3	-29.3	75%	> 20% Deficit
Neurosurgery	4	4.3	-0.3	7%	< 20% Deficit
OB/GYN	37.25	38.9	-1.65	4%	< 20% Deficit
Perinatology	2	-	-	-	-
Ophthalmology	17.5	18.7	-1.2	6%	< 20% Deficit
Orthopedics	30	24.6	5.4	-	above
Hand Surgery	1.75	-	-	-	-
Plastic Surgery	5.25	4.4	0.85	-	above
Urology	8.75	12.3	-3.55	29%	> 20% Deficit
Vascular/Cardiac/Thoracic	4	3.3	0.7	-	above
Peri		-	-	-	-
Sui		183.6	-48.85	27%	> 20% Deficit
Int					
Psy		62.4	-41.25	66%	> 20% Deficit
Psy		14.6	-9.6	66%	> 20% Deficit
Mei		77	-50.85	66%	> 20% Deficit

* Pediatric Specialists practicing in Anchorage, 10.75 was for comparison with the average benchmarks for the other 4 pediatric specialists.

* Surgical Specialists practicing in Anchorage, 134.75 was for comparison with the average benchmarks for the other 5.75 surgical specialists.

Primary Care Providers:

- Overall, Anchorage currently is drastically lacking adult primary care providers for internists.
- Family physicians are making up for some of the deficit of internists. There needs to be a focus in this area because it is affecting EMTALA and access to care.

Hospital Based Providers:

- Currently, Anchorage seems to have an adequate supply of physicians practicing anesthesiology and emergency medicine.
- There is a potential provider need or opportunity for physicians practicing pathology and radiology.

Medical Specialists:

- Currently, Anchorage seems to have an adequate supply of physicians practicing cardiology, endocrinology, nephrology, and physical medicine/rehab.
- There is a potential provider need or opportunity for physicians practicing in allergy/immunology, dermatology, gastroenterology, hematology/oncology, infectious diseases, neurology, preventive medicine, pulmonology, and rheumatology in Anchorage.
- This need is very critical in some of these areas.
- There were no available U.S. benchmarks to determine whether there is a potential provider need for physicians practicing geriatric medicine, pain management, radiation oncology, and sleep medicine.

Pediatric Specialists:

- Currently, Anchorage seems to have an adequate supply of neonatologists.
- There is a potential provider need or opportunity for physicians practicing pediatric allergy, pediatric cardiology, and pediatric oncology in Anchorage.
- There were no available U.S. benchmarks to determine whether there is a potential provider need for physicians practicing pediatric pulmonology, pediatric neurodevelopment, and pediatric intensive care in Anchorage.

Surgical Specialists:

- Currently, Anchorage seems to have an adequate supply of physicians practicing cardiac/thoracic surgery, orthopedic surgery, and plastic surgery.
- There is a potential provider need or opportunity for physicians practicing neurosurgery, OB/GYN, ophthalmology, general surgery, ENT, and urology.

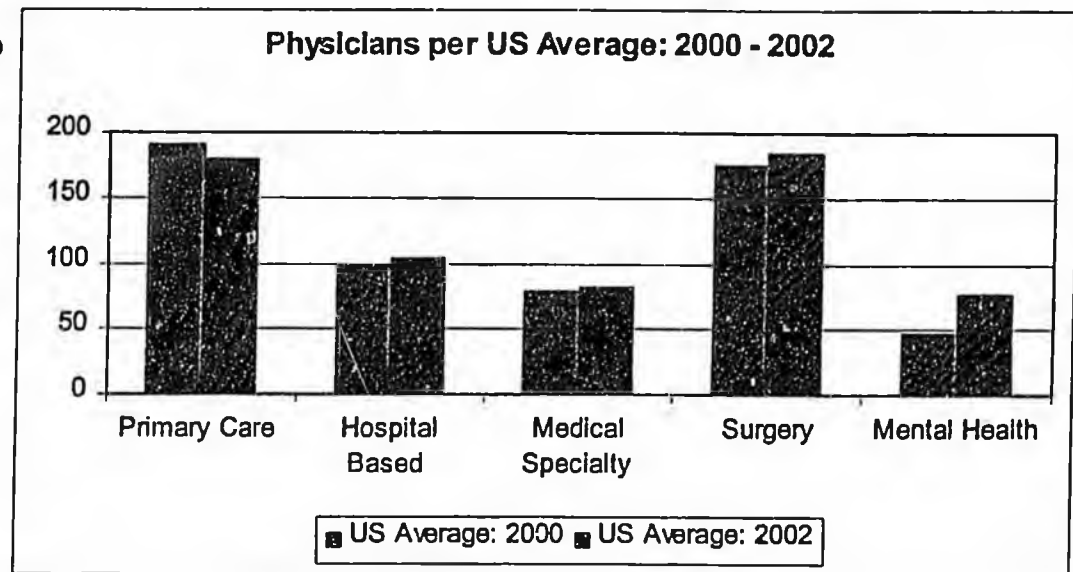
Mental Health Providers:

- There is a potential provider need or opportunity for physicians practicing in adult psychiatry and child psychiatry.

US Average Benchmarks Comparison:

The Physicians per US average benchmarks for the Anchorage area population have changed from 2000 to 2002 as shown in the graph to the right.

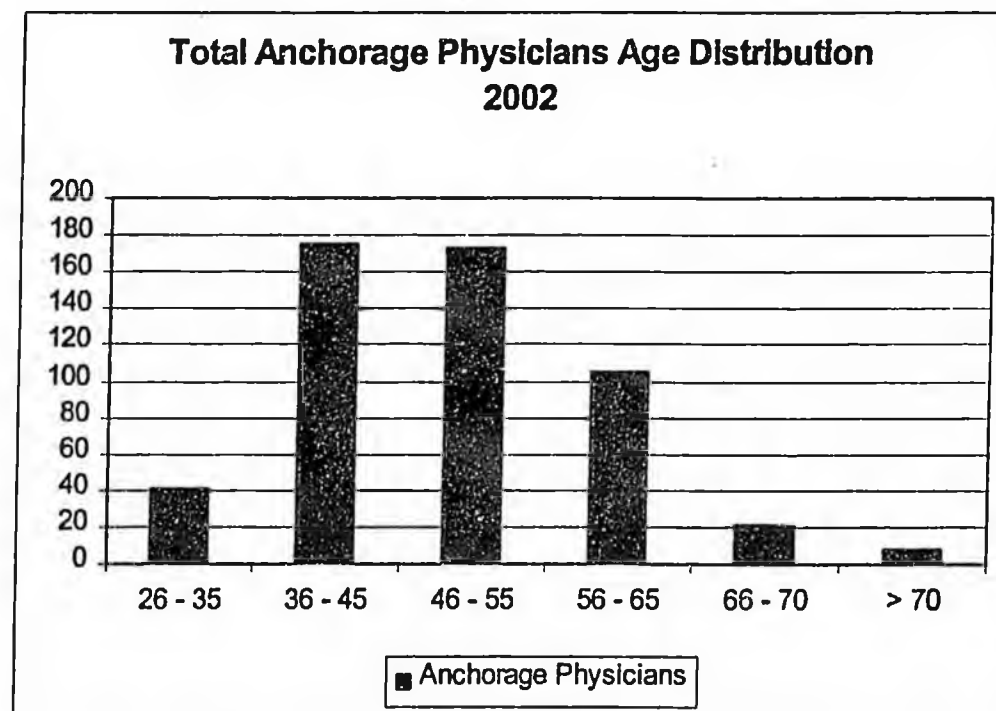
- The overall primary care US average benchmark has decreased from 190 in 2000 to 179 in 2002.
- The overall hospital based US average benchmark has increased from 97 in 2000 to 104.7 in 2002.
- The overall medical specialty US average benchmark has slightly increased from 78.6 in 2000 to 81.2 in 2002.
- The overall surgery US average benchmark has increased from 174.8 in 2000 to 183.6 in 2002.
- The overall mental health US average benchmark has increased from 47 in 2000 to 77 in 2002.



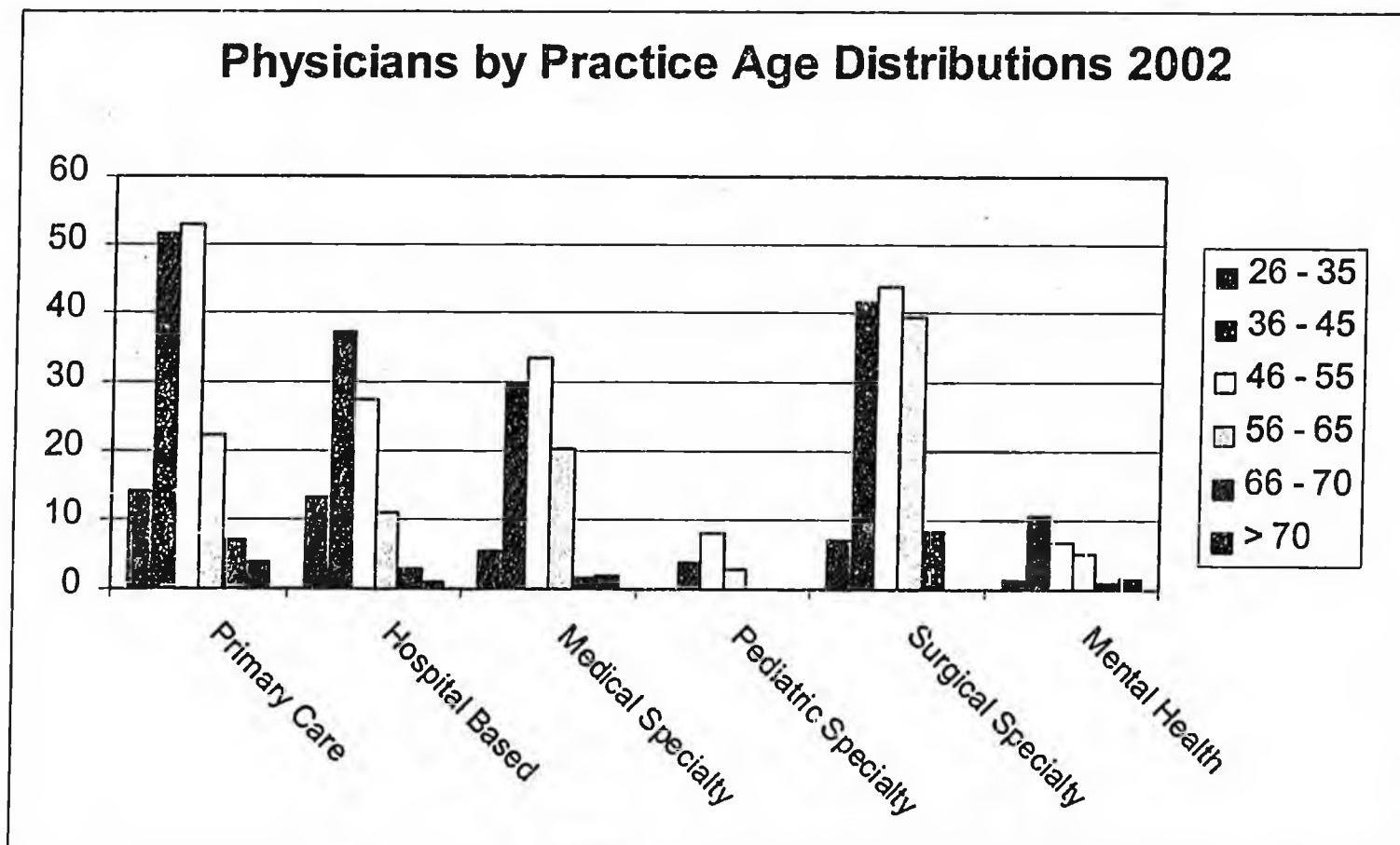
Age of Anchorage Physicians:

The current age distribution of the 524.85 Anchorage physicians (adjusted for time spent practicing) is shown in the graph to the right.

- 7.8% of the Anchorage physicians are between the ages of 26 and 35 years old.
- 33.5% of the Anchorage physicians are between the ages of 36 and 45 years old.
- 33% of the Anchorage physicians are between the ages of 46 and 55 years old.
- 20% of the Anchorage physicians are between the ages of 56 and 65 years old.
- 4.1% of the physicians are between the ages of 66 and 70 years old and 1.6% over 70 years old.
- 25.7% of the physicians are over 55 years old and 5.7% of the physicians are over 65 years old.

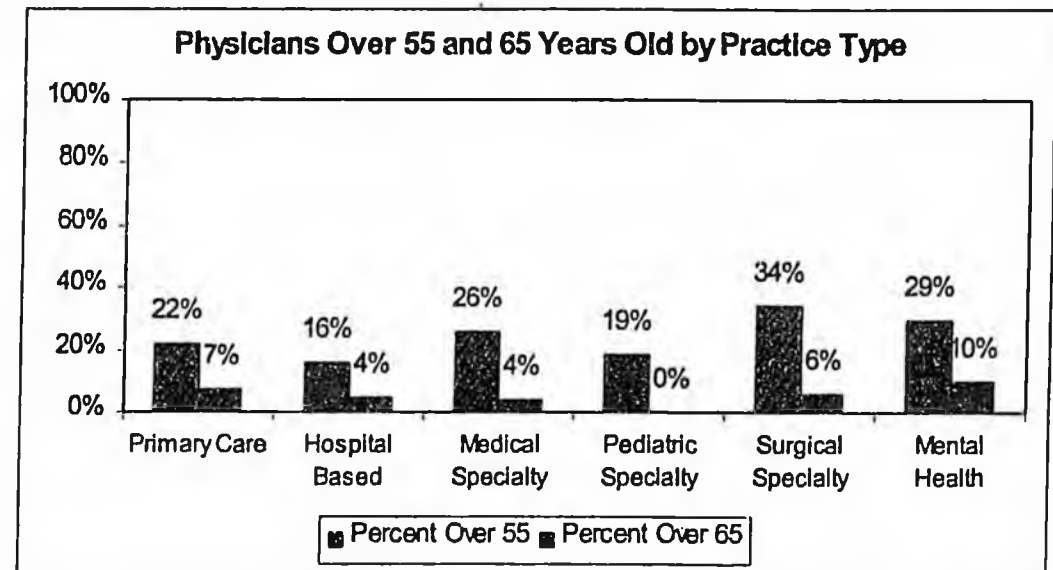


Physicians by Practice Age Distributions 2002



Physicians Over 55 and 65 Years Old:

- 22% of the Anchorage primary care physicians are over 55 years old. This includes the 7% that are over 65 years old.
- 16% of the Anchorage hospital based physicians are over 55 years old. This includes the 4% that are over 65 years old.
- 26% of the Anchorage medical specialty physicians are over 55 years old. This includes the 4% that are over 65 years old.
- 19% of the Anchorage pediatric specialty physicians are over 55 years old. There are no pediatric specialists over 65 years old.
- 34% of the surgical specialty physicians are over 55 years old. This includes the 6% that are over 65 years old.
- 29% of the mental health physicians are over 55 years old. This includes the 10% that are over 65 years old.



Population Growth Projections:

	1998	2003	2008	2013
Alaska	621,400	656,150	693,018	733,852
Anchorage	258,782	269,567	279,707	289,528

While not considered one of the fastest growing states in the US, Alaska's population growth is relatively constant with nearly half of the state population residing in the municipality of Anchorage.

The death rate for Alaska is consistently about half the national average, and the infant mortality rate is decreasing for both Alaska and the US. Currently, the infant mortality rate for Alaska is below the national average.

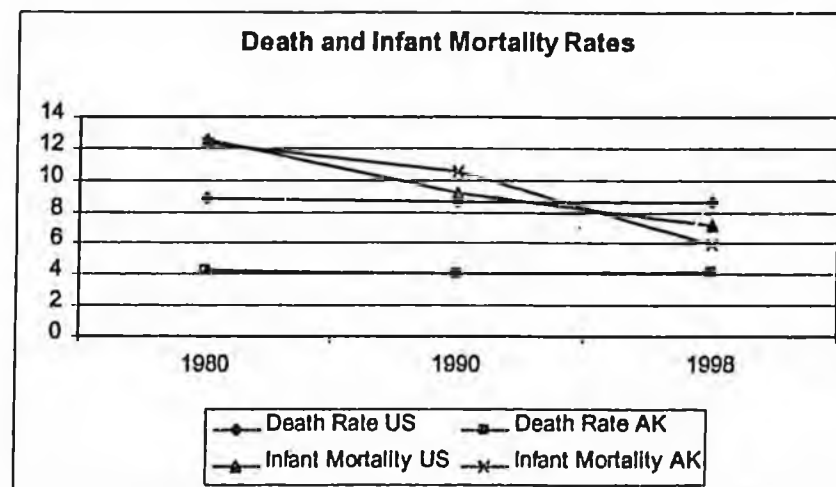
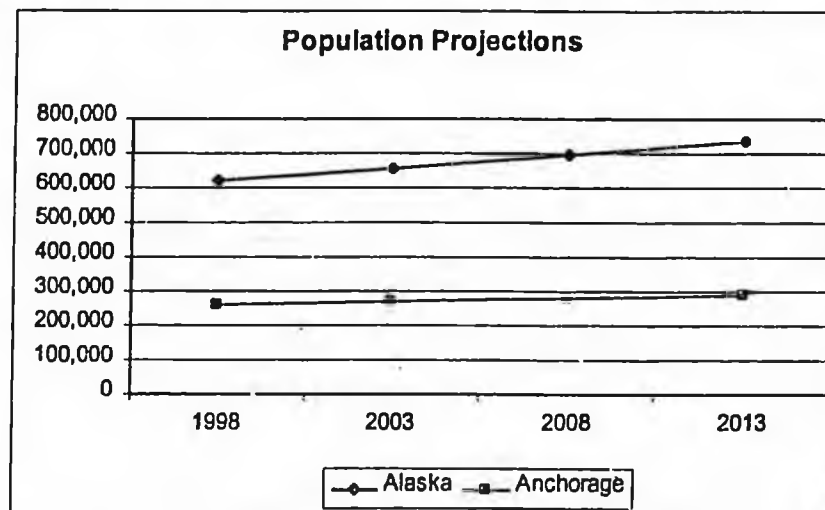
Historical Death Rate:

	1980	1990	1998
US	8.8	8.6	8.6
Alaska	4.3	4.0	4.2

Historical Infant Mortality Rate:

	1980	1990	1998
US	12.6	9.2	7.2
Alaska	12.3	10.5	5.9

Death rate, and infant mortality rates are fundamental statistics in the evaluation of the general health of a population.



*Death rate per 1,000 population

*Infant mortality rate per 1,000 live births

Sources: Alaska Dept. of Labor 1998, Statistical Abstract of the United States 2001

Death Rate by most Common Cause:

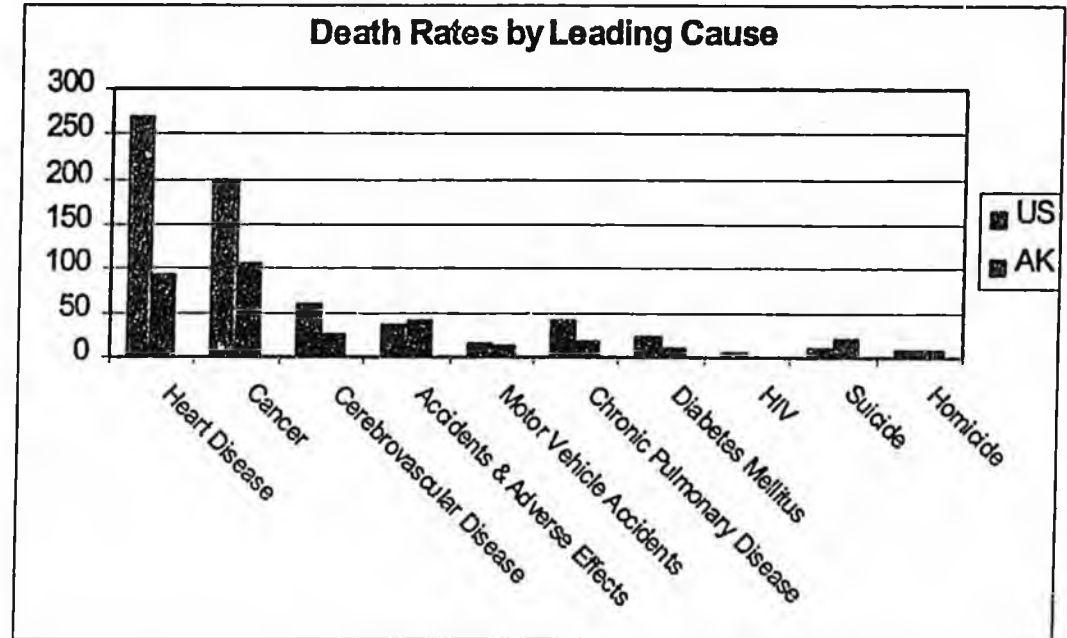
Cause	US	AK
Heart Disease	268.2	91.9
Cancer	200.3	106
Cerebro Vas D.	58.6	24.9
Accidents & Adv.	36.2	40.9
MV Accidents	16.1	11.7
Chronic Pulm D.	41.7	18.2
Diabetes	24	10.4
HIV	5	--
Suicide	11.3	21
Homicide	6.8	8

The Potential Need for Providers:

Deaths caused by accidents and other adverse effects are higher than the US average, which may suggest a greater need for ER, Ortho, and Trauma surgeons.

Alaska death rates caused by heart disease, cancer, cerebrovascular disease, chronic obstructive pulmonary disease, diabetes, and HIV are lower than the average of the United States. This suggests a diminished need for physicians with specialties of cardiology, hematology/oncology, pulmonology, and infectious diseases.

Alaska death rates caused by suicide is higher than the US average, which may suggest a greater need for mental health professionals.



*Deaths per 100,000 resident population

*HIV estimate for AK did not meet publishing standards

Source: Statistical Abstract of the United States, 2001

Alaska Population by Age:

Alaska has a higher percentage of young people under the age of 18 than the national average of the United States. Individuals under the age of 18 in the United States make up 25.7% of the population, while those under the age of 18 in Alaska make up 30.4% of the total population and 29.1% of the population in Anchorage.

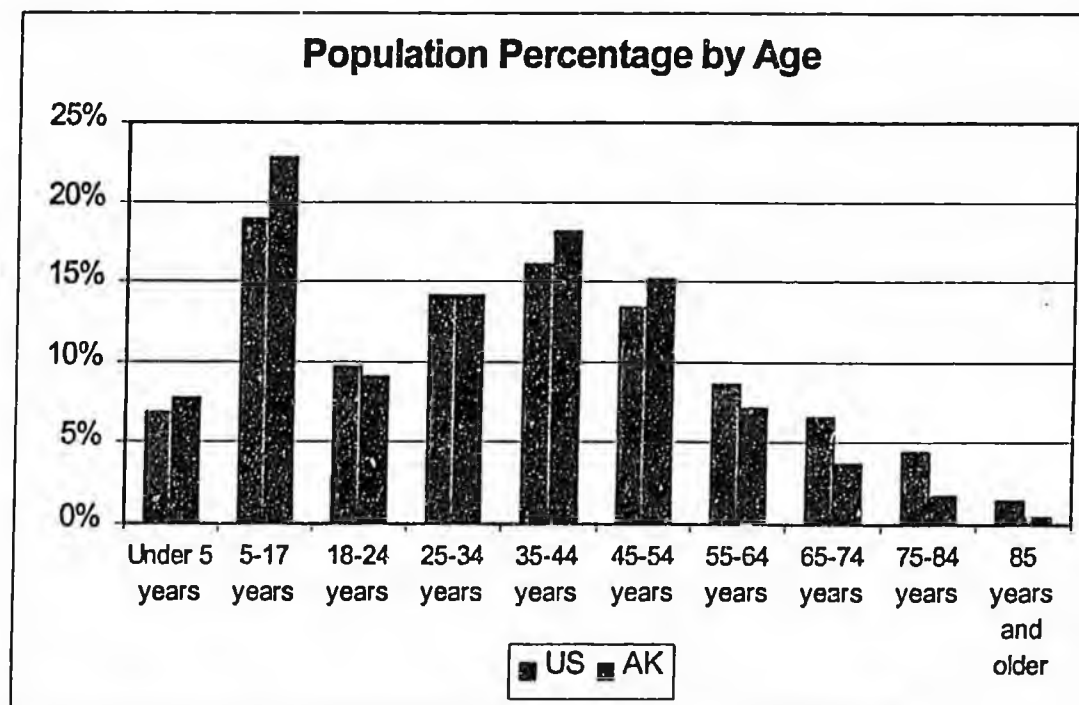
- This may suggest a greater need for pediatric providers.
- This may also suggest a greater need for orthopedic providers, as this population is more active.

Alaska has a significantly lower population of adults beyond the age of 55 than does the national average of the United States.

- This may suggest a decreased need for providers of older age diseases, such as cardiology, general surgery, etc.

Individuals over that age of 65 in the United States make up 12.4% of the population, while those over the age of 65 in the state of Alaska make up only 5.7% of the total population and 5.5% of the population in Anchorage. Alaska has the smallest senior population in the United States.

Life expectancy for Alaskans is 74.2 years, which is 1.6 years below the national average.



Source: Statistical Abstract of the United States, 2001

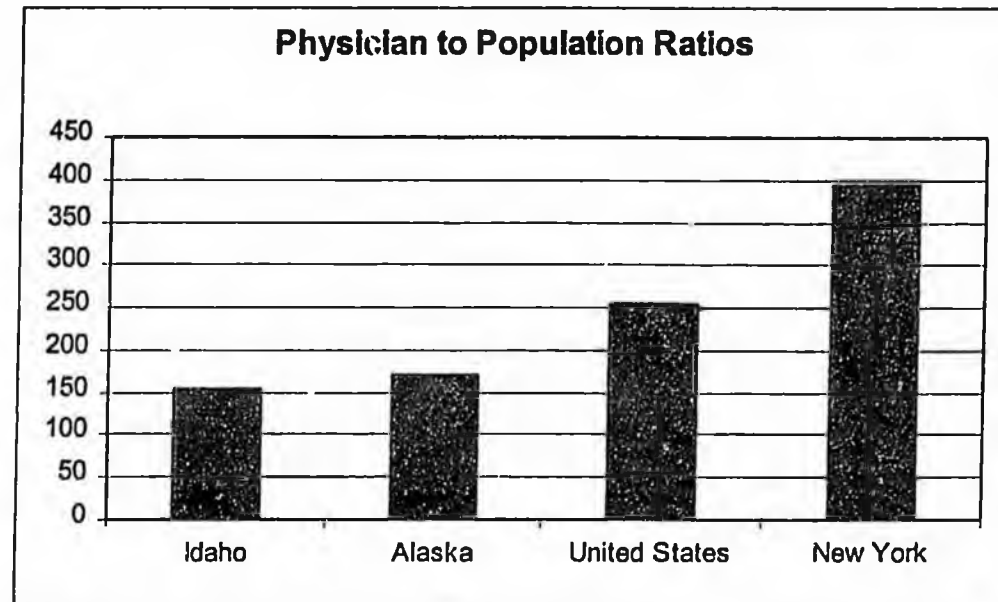
Physician to Population Ratios:

The United States has a physician ratio of 254 physicians per 100,000 resident population.

Alaska's physician ratio of 170 physicians per 100,000 resident population is the fourth smallest physician ratio in the United States. Alaska's physician ratio is 84 below the national average.

Idaho has the smallest physician ratio of 155 physicians per 100,000 resident population. Alaska physician ratio is only 15 above the smallest physician ratio in the United States.

New York has the largest physician ratio of 395 physicians per 100,000 resident population. New York's physician ratio is more than twice Alaska's physician ratio, which is 225 physicians per 100,000 resident population below New York.



*Physician ratio is the number of physicians per 100,000 resident population.

*Federally-employed persons and physicians with addresses unknown are excluded.

Source: Statistical Abstract of the United States, 2001

About the Surveys

The Institute for Circumpolar Health Studies was commissioned to distribute the 55 and older physician survey to the non-federally employed Anchorage physicians age 55 and older and the practice manager survey to the office managers of physician practices in the Anchorage area. The Committee worked with Circumpolar Health to develop the questions and the areas to be covered. The surveys were distributed around July 10, 2002 and the physicians and practice managers had until August 10, 2002 to return their surveys.

55 and Older Physician Survey Questions

- Are you a single practitioner?
- If you are in a group practice, what is the size of your group?
- Are you still practicing full-time?
- If no, how many hours are you practicing?
- Do you plan to reduce your hours in the next 3 years?
- If yes, how many hours do you plan to work?
- How many years do you plan to practice in Anchorage?
- Do you feel that your specialty is now under-represented in Anchorage?
- If you cut back or retire will it then be under-represented?
- What specialties in Anchorage do you feel are presently under-represented?

Practice Manager Survey Questions

- Is your practice recruiting new physicians?
- If yes, for what specialty?
- Have you already recruited new physicians who are not yet practicing?
- If yes, how many?
- If yes, in what specialties?
- If you have recruited in the last year, was it an addition or a replacement?
- For the physicians in your practice please note the percent of their time that they are seeing patients in primary care and the percent of their time that they are seeing patients in specialty care.
- Do you feel that the specialties (including primary care) represented by your physicians are under-represented in Anchorage?
- What specialties do you feel are under-represented in Anchorage?
- How long does a patient have to wait to get an appointment?

There were 134 of the 55 and older physician surveys distributed with 49 returned. There were 166 of the practice manager surveys distributed with 50 of them returned. This results in a 37% response rate for the 55 and older physician survey and a 30% response rate for the practice manager survey.

55 and Older Physician Survey Results

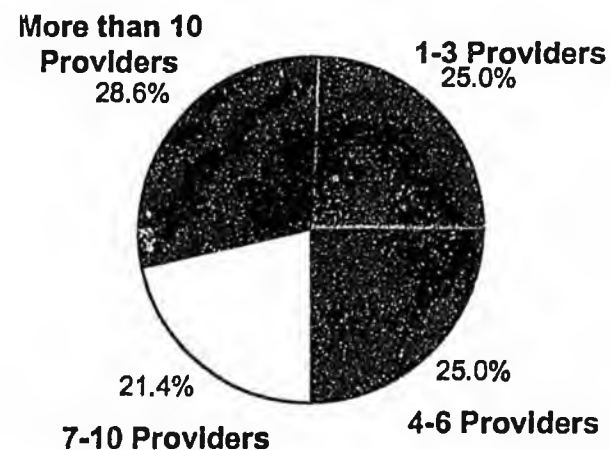
Question 1: Are you a single practitioner?

Of the 49 survey respondents, 48 answered this question with 20 (41.7%) indicating that they are a single practitioner and 28 (58.3%) indicating that they are in a group practice.



Question 2: If you are in a group practice, what is the size of the group?

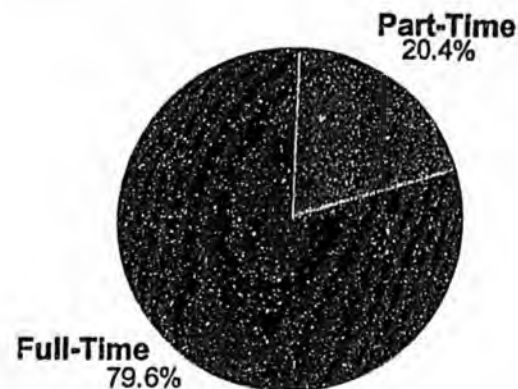
Of the 28 that indicated they are in a group practice, 7 (25.0%) are in a group with 1-3 providers, 7 (25.0%) are in a group with 4-6 providers, 6 (21.4%) are in a group with 7-10 providers, and 8 (28.6%) are in a group with more than 10 providers.



55 and Older Physician Survey Results

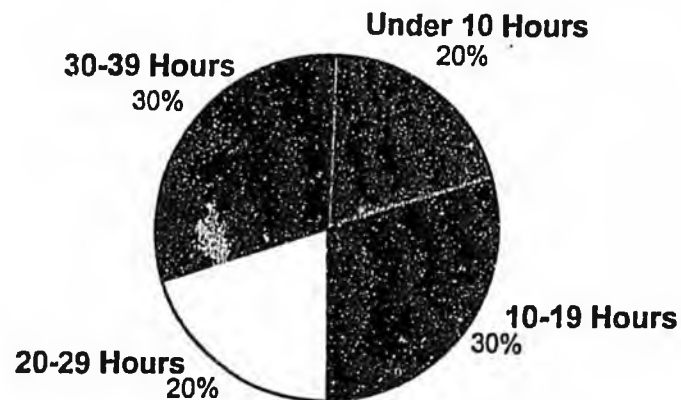
Question 3: Are you still practicing full-time?

Of the 49 survey respondents, 39 (79.6%) indicated that they are still practicing full-time and 10 (20.4%) indicated that they are not practicing full-time.



Question 4: If no, how many hours are you practicing?

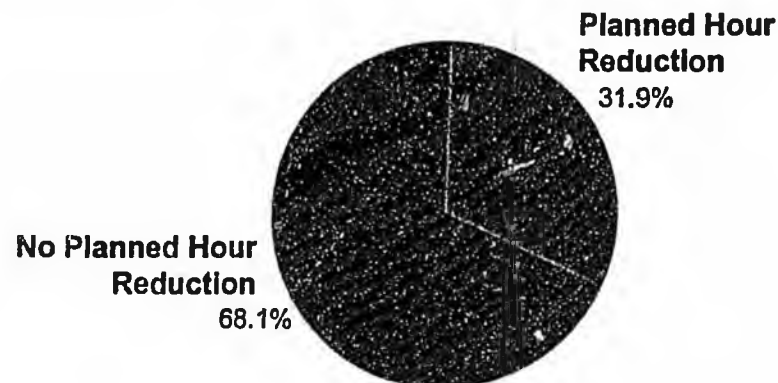
Of the 10 survey respondents that indicated they are not practicing full-time, 2 (20%) are practicing under 10 hours, 3 (30%) are practicing 10-19 hours, 2 (20%) are practicing 20-29 hours, and 3 (30%) are practicing 30-39 hours. The average number of hours practiced by the 10 that indicated they are not working full-time is 18.8 hours.



55 and Older Physician Survey Results

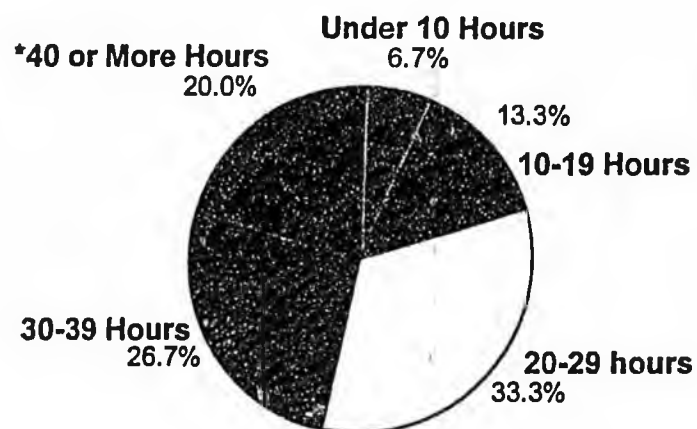
Question 5: Do you plan to reduce your hours in the next 3 years?

Of the 49 survey respondents, 47 answered this question with 15 (31.9%) indicating that they plan to reduce their hours in the next 3 years and 32 (68.1%) indicating that they do not plan to reduce their hours in the next 3 years.



Question 6: If yes, how many hours do you plan to work?

Of the 15 survey respondents that indicated they are planning to reduce their hours in the next 3 years, 1 (6.7%) plans to work under 10 hours, 2 (13.3%) plan to work 10-19 hours, 5 (33.3%) plan to work 20-29 hours, 4 (26.7%) plan to work 30-39 hours, and 3 (20%) plan to work 40 or more hours. The average number of work hours planned for those respondents who plan to reduce their hours in the next 3 years is 25.8 hours.

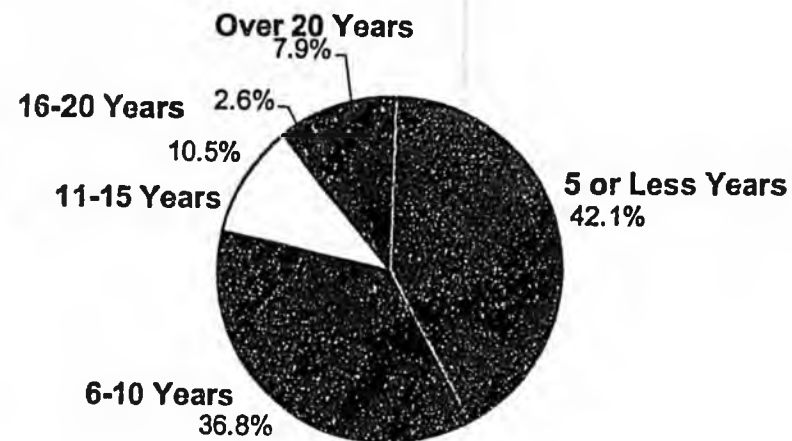


*The Physicians that indicated they plan to reduce their hours to 40 or more hours in the next 3 years are already working well over 40 hours per week and will continue to work over 40 hours after their planned hour reduction.

55 and Older Physician Survey Results

Question 7: How many years do you plan to practice in Anchorage?

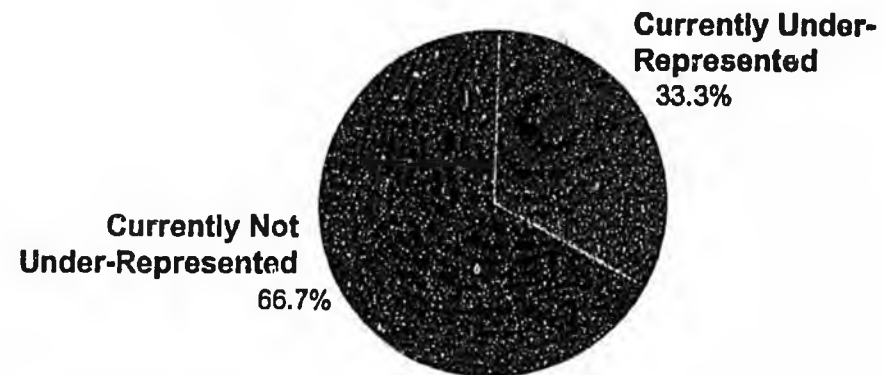
Of the 49 survey respondents, 38 answered this question with 16 (42.1%) indicating they plan to practice for five or less years, 14 (36.8%) planning to practice 6-10 years, 4 (10.5%) planning to practice 11-15 years, 1 (2.6%) planning to practice 16-20 years, and 3 (7.9%) planning to practice over 20 years in Anchorage. The average number of years these physicians plan to practice in Anchorage is 9.7 years.



55 and Older Physician Survey Results

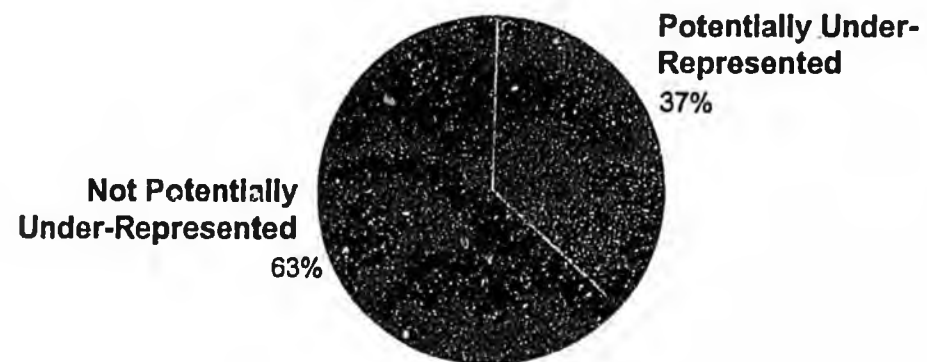
Question 8: Do you feel that your specialty is now under-represented in Anchorage?

Of the 49 survey respondents, 48 answered this question with 16 (33.3%) indicating that they feel their specialty is currently under-represented in Anchorage and 32 (66.7%) indicating that they do not feel that their specialty is currently under-represented in Anchorage.



Question 9: If you cut back or retire will it then be under-represented?

Of the 49 survey respondents, 46 answered this question with 17 (37%) indicating that if they cut back or retire that their specialty will be under-represented and 29 (63%) indicating that if they cut back or retire that their specialty will not be under-represented in Anchorage.



55 and Older Physician Survey Results

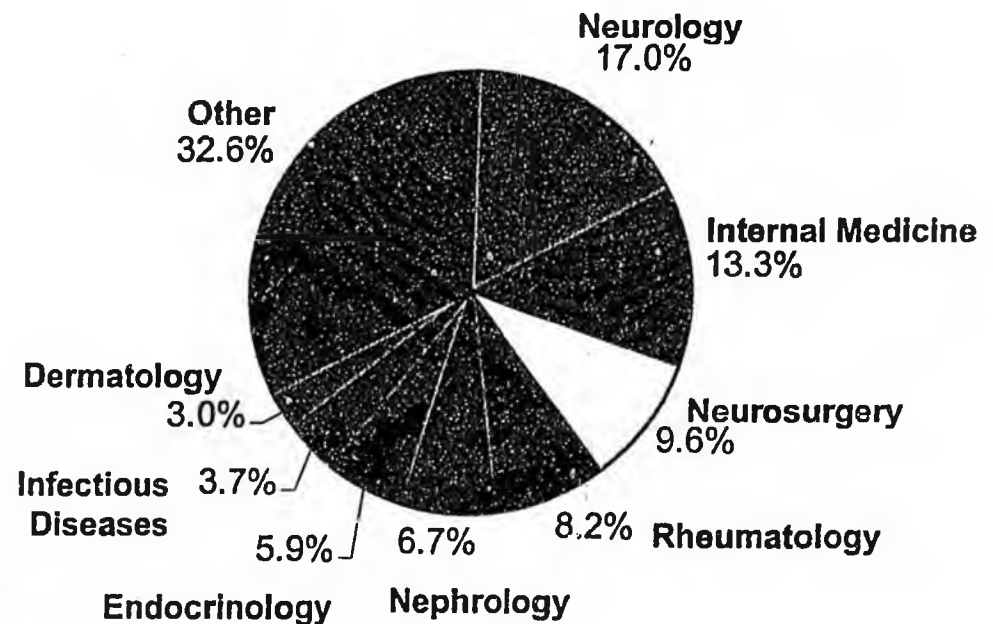
Question 10: What specialties in Anchorage do you feel are presently under-represented?

Greatest Perceived Under-Represented Specialties

Neurology (17.0%)
 Internal Medicine (13.3%)
 Neurosurgery (9.6%)
 Rheumatology (8.2%)
 Nephrology (6.7%)
 Endocrinology (5.9%)
 Infectious Diseases (3.7%)
 Dermatology (3.0%)

Other Perceived Under-Represented Specialties

Family Practice (2.2%)	Oncology (0.7%)
Gastroenterology (2.2%)	Orthopedics (0.7%)
Psychiatry (2.2%)	Pathology (0.7%)
Geriatric Medicine (1.5%)	Pediatric Neurology (0.7%)
Hand Surgery (1.5%)	Pediatric Neurosurgery (0.7%)
Pediatric Pulmonology (1.5%)	Pediatric Orthopedics (0.7%)
Pediatrics (1.5%)	Perinatology (0.7%)
Anesthesiology (0.7%)	Physicians in General (0.7%)
Colon/Rectal Surgery (0.7%)	Preventive Medicine (0.7%)
Critical Care (0.7%)	Radiation Oncology (0.7%)
Diabetes (0.7%)	Radiology (0.7%)
Hospitalists (0.7%)	Sleep (0.7%)
Intensivists (0.7%)	Urology (0.7%)



55 and Older Physician Survey Summary

- 79.6% of the 55 and older physicians surveyed are still practicing full-time.
- 31.9% noted that they plan to reduce their hours of practice in the next 3 years.
- The majority of these practitioners would then be working less than 25 hours per week.
- 42.1% of these practitioners plan to retire within 5 years and 36.8% within 10 years.
- 33% of the physicians felt that their specialty was already under-represented.
- 37% felt that their specialty would be under-represented when they retire or reduce their hours.
- The individual specialties that the surveyed physicians indicated were presently under-represented mirrored the data collected in this study.

Practice Manager Survey Results

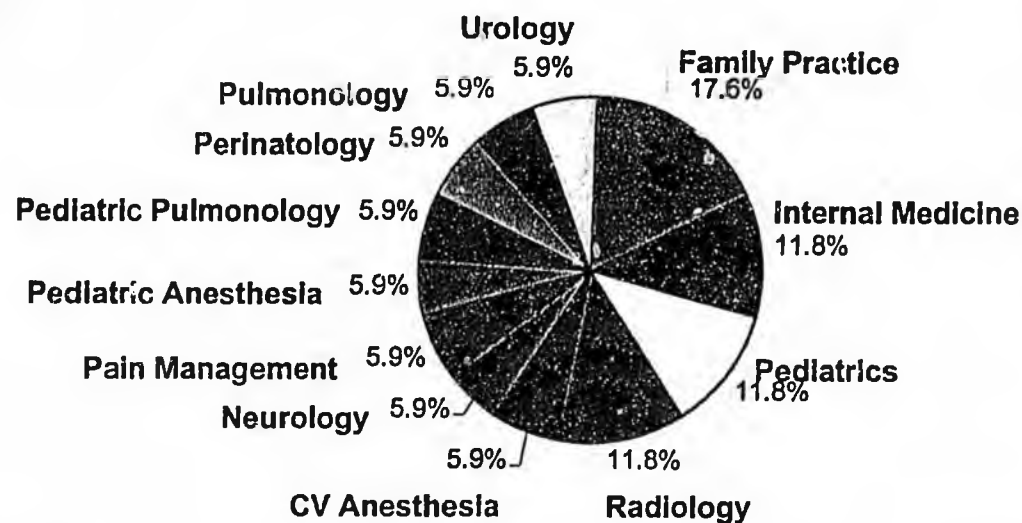
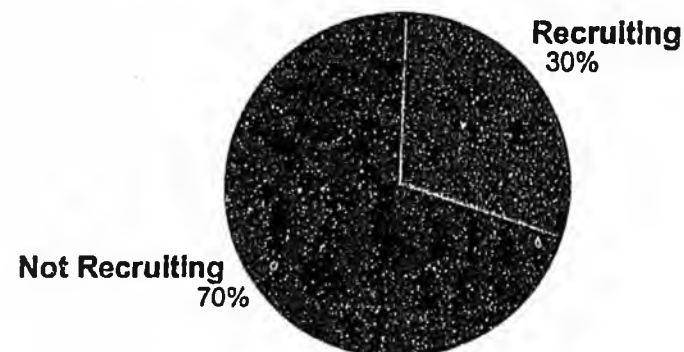
Question 1: Is your practice recruiting new physicians?

Of the 50 survey respondents, 15 (30%) indicated that their practice is recruiting new physicians and 35 (70%) indicated that their practice is not recruiting.

If yes, for what specialty?

The 15 practice managers that indicated they are recruiting are recruiting physicians in the specialties shown below. Two of the practice managers are recruiting for physicians in two different specialties. The number in front of the specialty refers to the number of practice managers that responded to the survey that are recruiting for physicians in that particular specialty.

- 3 Family Practice (17.6%)
- 2 Internal Medicine (11.8%)
- 2 Pediatrics (11.8%)
- 2 Radiology (11.8%)
- 1 CV Anesthesia (5.9%)
- 1 Neurology (5.9%)
- 1 Pain Management (5.9%)
- 1 Pediatric Anesthesia (5.9%)
- 1 Pediatric Pulmonology (5.9%)
- 1 Perinatology (5.9%)
- 1 Pulmonology (5.9%)
- 1 Urology (5.9%)



Practice Manager Survey Results

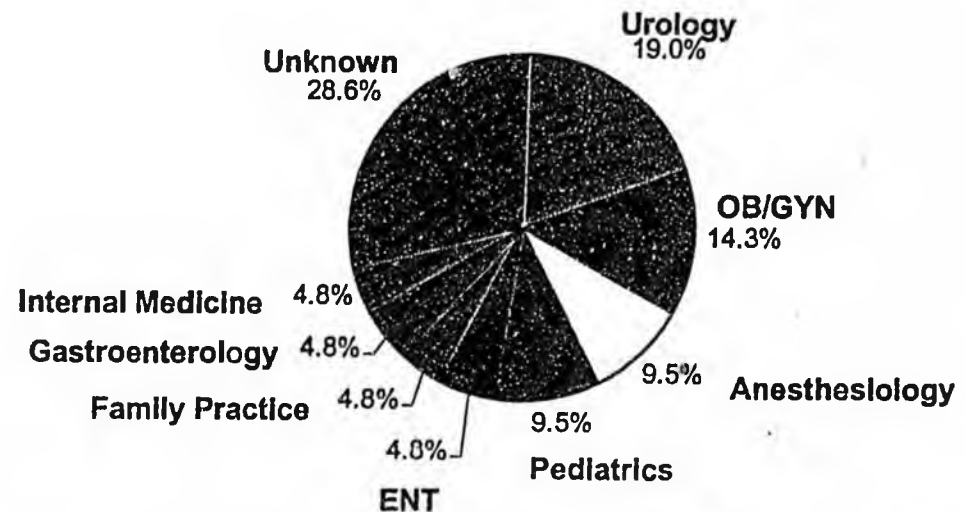
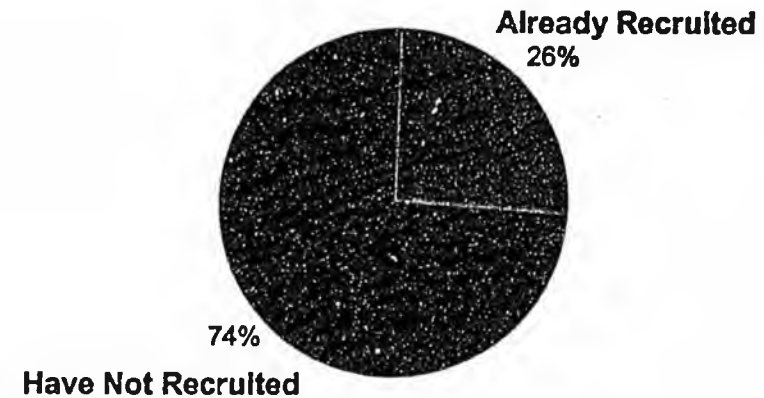
Question 2: Have you already recruited new physicians who are not yet practicing?

Of the 50 survey respondents, 13 (26%) indicated that they have already recruited new physicians who are not yet practicing and 37 (74%) have not already recruited physicians that are not yet practicing.

**If yes, how many?
If yes, in what specialties?**

The 13 practice managers that indicated in the previous question that they have already recruited new physicians have recruited 21 new physicians who are not yet practicing. The specialties for 6 of these newly recruited physicians were not listed on the survey.

- 4 Urology (19.0%)
- 3 OB/GYN (14.3%)
- 2 Anesthesiology (9.5%)
- 2 Pediatrics (9.5%)
- 1 ENT (4.8%)
- 1 Family Practice (4.8%)
- 1 Gastroenterology (4.8%)
- 1 Internal Medicine (4.8%)
- 6 Unknown specialties (28.6%)



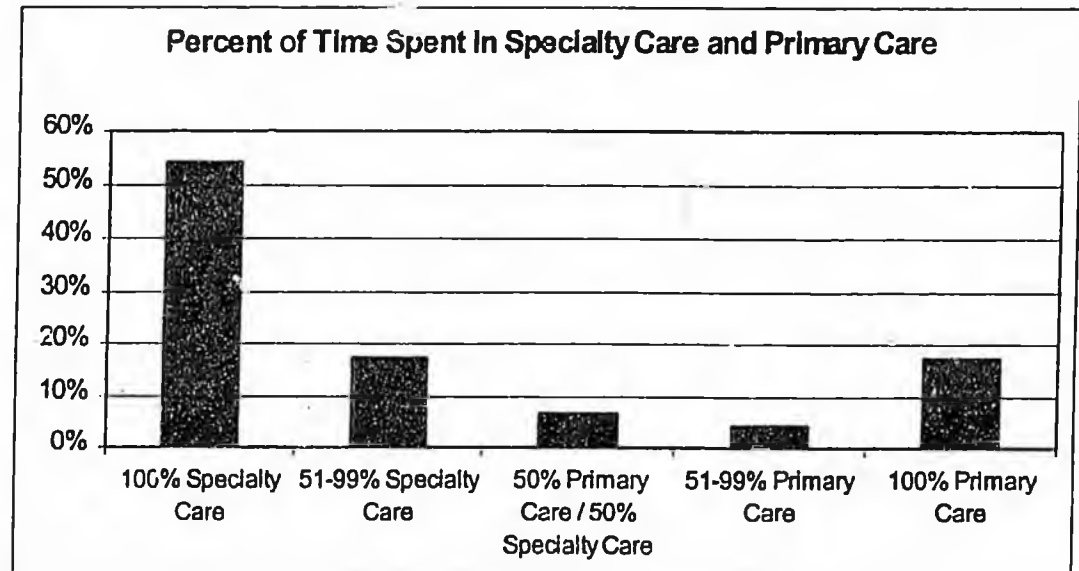
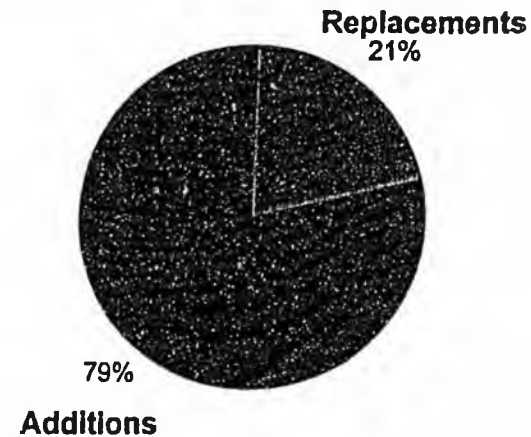
Practice Manager Survey Results

Question 3: If you have recruited in the last year, was it an addition or a replacement?

Of those that have recruited in the last year, 15 (78.9%) were additions and 4 (21.1%) were replacements.

Question 4: For the physicians in your practice please note the percent of their time that they are seeing patients in primary care and specialty care.

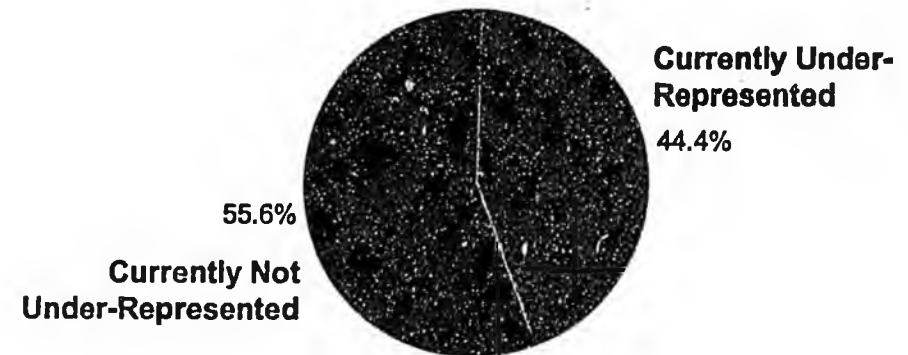
Of those 46 practice managers that answered this question, 25 (54.4%) indicated that the physicians in their practice see patients in specialty care 100% of the time, 8 (17.4%) indicated that the physicians in their practice see the majority of their patients in specialty care (51-99% of the time) with their remaining time seeing patients in primary care, 5 (6.5%) indicated that the physicians in their practice see patients 50% of their time in primary care and 50% of their time in specialty care, 2 (4.3%) indicated that the physicians in their practice see the majority of patients in primary care 51-99% of the time with the remaining in specialty care, and 8 (17.4%) indicated that the physicians in their practice see patients in primary care 100% of the time. 28.2% of the surveyed practice managers indicated that the physicians in their practice spend part of their time providing specialty care and part providing primary care. These specialists that are also providing primary care are partly filling in for the lack of primary care physicians in Anchorage.



Practice Manager Survey Results

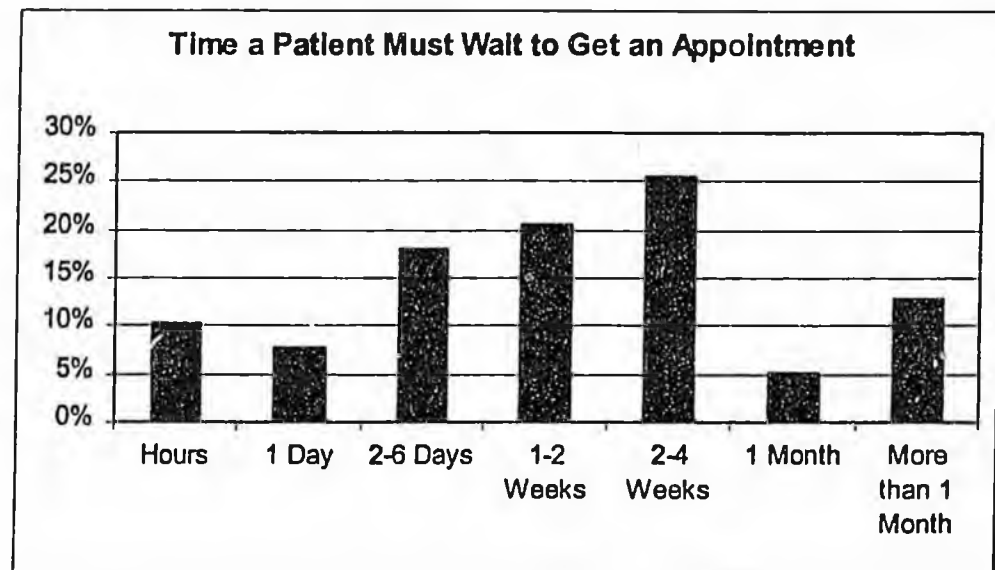
Question 5: Do you feel that the specialties (Including primary care) represented by your physicians are under-represented in Anchorage?

Of the 45 practice managers that answered this question, 20 (44.4%) feel that their specialties are under-represented in Anchorage and 25 (56.6%) do not feel that their specialties are under-represented in Anchorage.



Question 7: How long does a patient have to wait to get an appointment?

Of the 39 practice managers that answered this question, 4 (10.3%) indicated that patients have to wait only hours to get an appointment, 3 (7.7%) indicated that patients have to wait 1 day to get an appointment, 7 (17.9%) indicated that patients have to wait 2-6 days to get an appointment, 8 (20.5%) indicated that patients have to wait 1-2 weeks (7-14 days) to get an appointment, 10 indicated that patients have to wait 2-4 weeks (15-28 days) to get an appointment, 2 (5.1%) indicated that patients have to wait one month to get an appointment, and 5 (12.8%) indicated that patients have to wait more than one month to get an appointment. The average amount of time that a patient must wait to get an appointment among the practice managers that answered this question is 18 days.



Practice Manager Survey Results

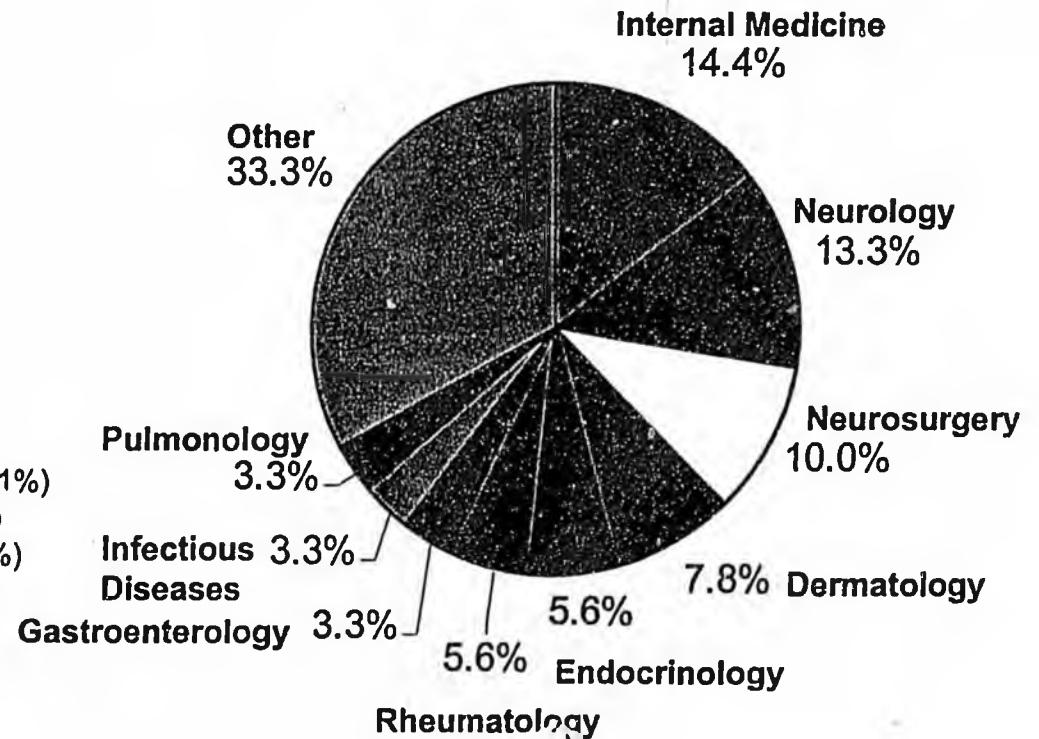
Question 6: What specialties do you feel are under-represented in Anchorage?

Greatest Perceived Under-Represented Specialties

Internal Medicine (14.4%)
 Neurology (13.3%)
 Neurosurgery (10.0%)
 Dermatology (7.8%)
 Endocrinology (5.6%)
 Rheumatology (5.6%)
 Gastroenterology (3.3%)
 Infectious Diseases (3.3%)
 Pulmonology (3.3%)

Other Perceived Under-Represented Specialties

Allergy (2.2%)	Pediatric Cardiac Surgery (1.1%)
Nephrology (2.2%)	Pediatric Dermatology (1.1%)
Pediatric Neurology (2.2%)	Pediatric Endocrinology (1.1%)
Psychiatry (2.2%)	Pediatric Intensivists (1.1%)
Anesthesiology (1.1%)	Pediatric Specialty (1.1%)
Burn Therapy (1.1%)	Pediatric Surgery (1.1%)
Family Practice (1.1%)	Pediatrics (1.1%)
Female Urology (1.1%)	Radiology (1.1%)
General Surgery (1.1%)	Rehab (1.1%)
Oncology (1.1%)	Specialty (1.1%)
Orthopedics (1.1%)	Surgery (1.1%)
Pain Management (1.1%)	Therapy (1.1%)
Pathology (1.1%)	Urology (1.1%)





Practice Manager Survey Summary

- 30% of the practice managers surveyed are presently recruiting for new physicians.

- 26% noted that they had recruited new physicians within the last year.

- The majority of these newly recruited physicians are additions to their staff and not replacements for retiring physicians.

- 28.2% of the surveyed practice managers indicated that the physicians in their practice spend part of their time providing specialty care and part providing primary care. These specialists that are also providing primary care are partly filling in for the lack of primary care physicians in Anchorage. 54.4% of the surveyed practice managers indicated that their physicians spend all of their time providing specialty care. 17.4% of the surveyed practice managers indicated that their physicians spend all their time providing primary care.

- The individual specialties that the surveyed practice managers indicated were presently under-represented also mirrored the data collected in this study.

Primary Care Providers:

- There is a drastic need for more adult primary care providers in Anchorage. The U.S. benchmark comparison data indicates that the number of Anchorage family practitioners is above the U.S. average benchmark and the number of Anchorage pediatricians is comparable to the U.S. average benchmark. However, the number of internists is much lower than the U.S. average benchmark.
- The family practitioners are partly filling in for the lack of internists. Still, the combined number of family practitioners and internal medicine providers is below the combined national average benchmark.
- There are access problems especially due to a lack of Medicare acceptance by primary care providers.
- Alaska's population is relatively younger than the US average, which may suggest that a larger number of pediatricians are needed than the U.S. average benchmark suggests.
- The 55 and older physicians and the practice managers surveyed perceive a need for additional primary care providers in the Anchorage community. Internal medicine was the highest perceived under-represented specialty in Anchorage among the practice managers surveyed and the second highest perceived under-represented specialty among the 55 and older physicians surveyed. Family practice was also a perceived under-represented specialty among the surveyed practice managers and 55 and older physicians.
- 22% of the primary care physicians are over age 55, which includes the 7% that are over age 65. Of the 55 and older physicians surveyed, 42.1% indicated that they plan to retire within 5 years and an additional 36.8% indicated that they plan to retire in 6 to 10 years. Therefore, an estimated 9.3% of all primary care providers will retire within 5 years and an additional estimated 8.1% of primary care providers will retire within 10 years.
- 30% of the surveyed practice managers (15 out of 50) are currently recruiting physicians. Of these 15 recruiting practice managers, 3 (17.6%) are recruiting family practitioners, 2 (11.8%) are recruiting internal medicine specialists, and 2 (11.8%) are recruiting pediatricians.
- 26% of the surveyed practice managers indicated that they had already recruited new physicians who are not yet practicing. Of these 21 newly recruited physicians, 2 are pediatricians, 1 is a family practitioner, and 1 is an internal medicine specialist.

Hospital Based Providers:

- U.S. benchmark comparison data indicated that Anchorage has adequate supply of physicians practicing anesthesiology and emergency medicine.
- U.S. benchmark comparison data indicated that a provider need currently exists for physicians practicing pathology and radiology in Anchorage.
- A large number of emergency medicine providers are needed due to Alaska's relatively young population and high number of accidents, as well as the lack of primary care providers.
- The 55 and older physicians and the practice managers surveyed perceive a need for additional hospital based providers in the Anchorage community. Anesthesiology, emergency medicine, pathology, and radiology were all perceived under-represented specialties among the 55 and older physicians surveyed. Anesthesiology, pathology, and radiology were perceived under-represented specialties in Anchorage among the practice managers surveyed.
- 16% of the hospital based physicians are over age 55, which includes the 4% that are over age 65. Of the 55 and older physicians surveyed, 42.1% indicated that they plan to retire within 5 years and an additional 36.8% indicated that they plan to retire in 6 to 10 years. Therefore, an estimated 6.7% of all hospital based providers will retire within 5 years and an additional estimated 5.9% of hospital based providers will retire within 10 years.
- 30% of the surveyed practice managers (15 out of 50) are currently recruiting physicians. Of these 15 recruiting practice managers, 2 (11.8%) are recruiting radiologists.
- 26% of the surveyed practice managers indicated that they had already recruited new physicians who are not yet practicing. Of these 21 newly recruited physicians, 2 are anesthesiologists.

Medical Specialists:

- U.S. benchmark comparison data indicated that Anchorage has an adequate supply of physicians practicing cardiology, endocrinology, nephrology, and physical medicine/rehab.
- U.S. benchmark comparison data indicated that a provider need currently exists for physicians practicing allergy/immunology, dermatology, gastroenterology, hematology/oncology, infectious diseases, neurology, preventive medicine, pulmonology, and rheumatology in Anchorage. This need is very critical in some of these areas.
- There were no available U.S. benchmarks to determine whether there is a potential provider need for physicians practicing geriatric medicine, pain management, radiation oncology, and sleep in Anchorage.
- Alaska death rates caused by heart disease, cancer, cerebrovascular disease, chronic obstructive pulmonary disease, diabetes, and HIV are lower than the average of the United States. This suggests a diminished need for physicians with specialties of cardiology, hematology/oncology, pulmonology, and infectious diseases.
- Alaska has a significantly lower population of adults beyond the age of 55 than the national average of the United States. This may suggest a decreased need for providers of older age diseases, such as cardiology.
- The Anchorage cardiology group has a statewide presence, which could shift the figures toward need.
- There is a crisis of access in neurology.
- The 55 and older physicians and the practice managers surveyed perceive a need for additional medical specialists in the Anchorage community. Neurology was the highest perceived under-represented specialty in Anchorage among the physicians age 55 and over surveyed and the second highest perceived under-represented specialty among the practice managers surveyed. The other perceived under-represented specialties are rheumatology, dermatology, nephrology, endocrinology, infectious diseases, gastroenterology, pulmonology, allergy, oncology, urology, geriatric medicine, pain management, rehab, sleep, preventive medicine, and radiation oncology.
- 26% of the medical specialists are over age 55, which includes the 4% that are over age 65. Of the 55 and older physicians surveyed, 42.1% indicated that they plan to retire within 5 years and an additional 36.8% indicated that they plan to retire in 6 to 10 years. Therefore, an estimated 10.9% of all medical specialists will retire within 5 years and an additional estimated 9.6% of medical specialists will retire within 10 years.
- 30% of the surveyed practice managers (15 out of 50) are currently recruiting physicians. Of these 15 recruiting practice managers, 1 (5.9%) is recruiting neurologists, 1 (5.9%) is recruiting pain management physicians, 1 (5.9%) is recruiting pulmonologists, and 1 (5.9%) is recruiting urologists.
- 26% of the surveyed practice managers indicated that they had already recruited new physicians who are not yet practicing. Of these 21 newly recruited physicians, 4 are urologists and 1 is a gastroenterologist.

Pediatric Specialists:

- U.S. benchmark comparison data indicated that Anchorage has an adequate supply of neonatologists.
- U.S. benchmark comparison data indicated that a provider need currently exists for physicians practicing pediatric allergy, pediatric cardiology, and pediatric oncology in Anchorage.
- There were no available U.S. benchmarks to determine whether there is a potential provider need for physicians practicing pediatric pulmonology, pediatric neurodevelopment, and pediatric intensive care in Anchorage.
- Alaska's population is relatively younger than the US average, which may suggest that a larger number of pediatric specialists are needed than the U.S. average benchmark suggests.
- The 55 and older physicians and the practice managers surveyed both perceive a need for additional pediatric specialists in the Anchorage community. These perceived under-represented pediatric specialties include pediatric neurology, pediatric pulmonology, pediatric dermatology, pediatric endocrinology, pediatric intensivists, and pediatric specialists in general.
- 19% of the pediatric specialists are over age 55. Of the 55 and older physicians surveyed, 42.1% indicated that they plan to retire within 5 years and an additional 36.8% indicated that they plan to retire in 6 to 10 years. Therefore, an estimated 8.0% of all pediatric specialists will retire within 5 years and an additional estimated 7.0% of pediatric specialists will retire within 10 years.
- 30% of the surveyed practice managers (15 out of 50) are currently recruiting physicians. Of these 15 recruiting practice managers, 1 (5.9%) is recruiting pediatric anesthesiologists and 1 (5.9%) is recruiting pediatric pulmonologists.



Surgical Specialists:

- U.S. benchmark comparison data indicated that Anchorage has an adequate supply of physicians practicing cardiac/thoracic surgery, orthopedic surgery, and plastic surgery.
- U.S. benchmark comparison data indicated that a provider need currently exists for physicians practicing neurosurgery, OB/GYN, ophthalmology, general surgery, ENT, and urology.
- A large number of orthopedics are needed due to the relatively young population and the large number of accidents. Also, orthopedics are full and there is an access problem. Although the benchmark comparison data indicated that Anchorage has an adequate supply of orthopedics, more may be needed.
- Alaska has a significantly lower population of adults beyond the age of 55 than does the national average of the United States. This may suggest a decreased need for providers of older age diseases, such as general surgery.
- The 55 and older physicians and the practice managers surveyed both perceive a need for additional surgical specialists in the Anchorage community. Neurosurgery was the third highest perceived under-represented specialty in Anchorage among the practice managers surveyed and among the 55 and older physicians surveyed. Some of the other perceived under-represented medical specialties include orthopedics, pediatric neurosurgery, pediatric orthopedics, pediatric cardiac surgery, pediatric surgery, general surgery, and colon/rectal surgery.
- 34% of the surgical specialists are over age 55, which includes the 6% that are over age 65. Of the 55 and older physicians surveyed, 42.1% indicated that they plan to retire within 5 years and an additional 36.8% indicated that they plan to retire in 6 to 10 years. Therefore, an estimated 14.3% of surgical specialists will retire within 5 years and an additional estimated 12.5% of surgical specialists will retire within 10 years.
- 26% of the surveyed practice managers indicated that they had already recruited new physicians who are not yet practicing. Of these 21 newly recruited physicians, 3 are OB/GYN physicians.



Mental Health Providers:

- U.S. benchmark comparison data indicated that Anchorage has a significant need for both adult and child psychiatrists.
- Alaska death rates caused by suicide is higher than the US average, which may suggest a greater need for mental health professionals.
- The 55 and older physicians and the practice managers surveyed perceive a need for additional mental health providers. Some of the respondents of the 55 and older survey and the practice manager survey named psychiatry as an under-represented specialty in Anchorage.
- 29% of the mental health providers are over age 55, which includes the 10% that are over age 65. Of the 55 and older physicians surveyed, 42.1% indicated that they plan to retire within 5 years and an additional 36.8% indicated that they plan to retire in 6 to 10 years. Therefore, an estimated 12.2% of mental health providers will retire within 5 years and an additional estimated 10.7% of mental health providers will retire within 10 years.
- None of the practice managers that responded to the survey indicated that they are planning to recruit psychiatrists or have already recruited psychiatrists who are not yet practicing.



Suggested Next Steps:

- Present the physician need assessment to the PAMC Medical Executive committee in September
- Present the physician need assessment to the PAMC and PHSA leadership in September
- Present the physician need assessment to the PHSA Alaska Region Board in October

These presentations will:

- Introduce the 2002 Anchorage physician data
- Compare the 2002 data with the prior physician data
- Introduce the results of the 55 and older physician survey and the practice manager survey
- Raise the issues of the under-served specialties, including the access to care issues
- Raise the issues of the most effective ways to recruit for under-served specialties as they exist presently and in the future

Jim Jordan

From: "Ron Neupauer" <ronn@miec.com>
To: "Jim Jordan" <asma@alaska.net>
Cc: "Dick Mello (E-mail)" <dickm@miec.com>; "Steve Stimmel (E-mail)" <steves@miec.com>
Sent: Tuesday, February 03, 2004 12:41 PM
Attach: MICRA effect 2003.xls; Milliman Med Mal Study.doc; Milliman NPDB Med Mal Data.xls; Jan'04 med mal article - HealthTracking.pdf; Contingencies article 11-03 - caps work.pdf; 2003 Joint Comm Rept on Med Mal.pdf
Subject: RE: Tort Reform

Glad you asked. The best 'single pick' exhibit of MICRA's effectiveness in holding down malpractice costs is the comparison of California's average premium for 3 representative specialties (internal medicine, general surgery, ob/gyn) with that of the five highest priced states (usually Florida, New York, Michigan, Texas & Illinois). The data is from Medical Liability Monitor which surveys doctor-owned companies each year. It's attached as "MICRA effect 2003"

MIEC's Alaska rates are 13% higher than those applicable to Northern California – this applies to all specialties and classes.

As far as studies are concerned, I have a few to offer

- 1- Abstract of a 2003 Milliman (actuaries/consultants) study showing the effectiveness of caps on damages in holding down awards, using data from the NPDB.
- 2- An article from the January 21, 2004 issue of Health Affairs describing the effect of caps on damages
- 3- The complete Milliman study published in the November, 2003 issue of Contingencies
- 4- A Joint Congressional Committee report published in 2003 which studies the extent and effect of the malpractice crisis. This study, on page 21 credits California's MICRA reforms with keeping malpractice loss costs, and premiums relatively modest, compared with the 'crisis states' that have no tort reform

This seems an ideal year to pass stronger tort reforms in Alaska. Much of the country is reeling from a continuing malpractice insurance crisis. With the supply of physicians in Alaska already at risk, any tort lottery induced spike in claims costs and subsequent needed premium hikes could be devastating to patients' access to proper medical care.

We look forward to working with you in this effort.

Ron

-----Original Message-----

From: Jim Jordan [mailto:asma@alaska.net]
Sent: Tuesday, February 03, 2004 11:40 AM
To: Ron Neupauer
Subject: Tort Reform

Ron,

We are definitely on the "ramp-up" in anticipation of the introduction of a tort reform bill setting the cap for non-economic damages at \$250,000. Bill might be introduced as early as Monday.

Because the 250K cap is the MICRA "gold standard" comparison to California will be asked for. For 2004, do you have or can you easily produce a comparison between AK rates by specialty and those for California (No. Cal.?)? Obviously, we want to show that California has lower rates somewhat attributed to the 250K cap.

Also, do you by any chance have a copy of any actuarial studies that show the 250K cap to be the most important element in impacting rates? I have a 1997 American

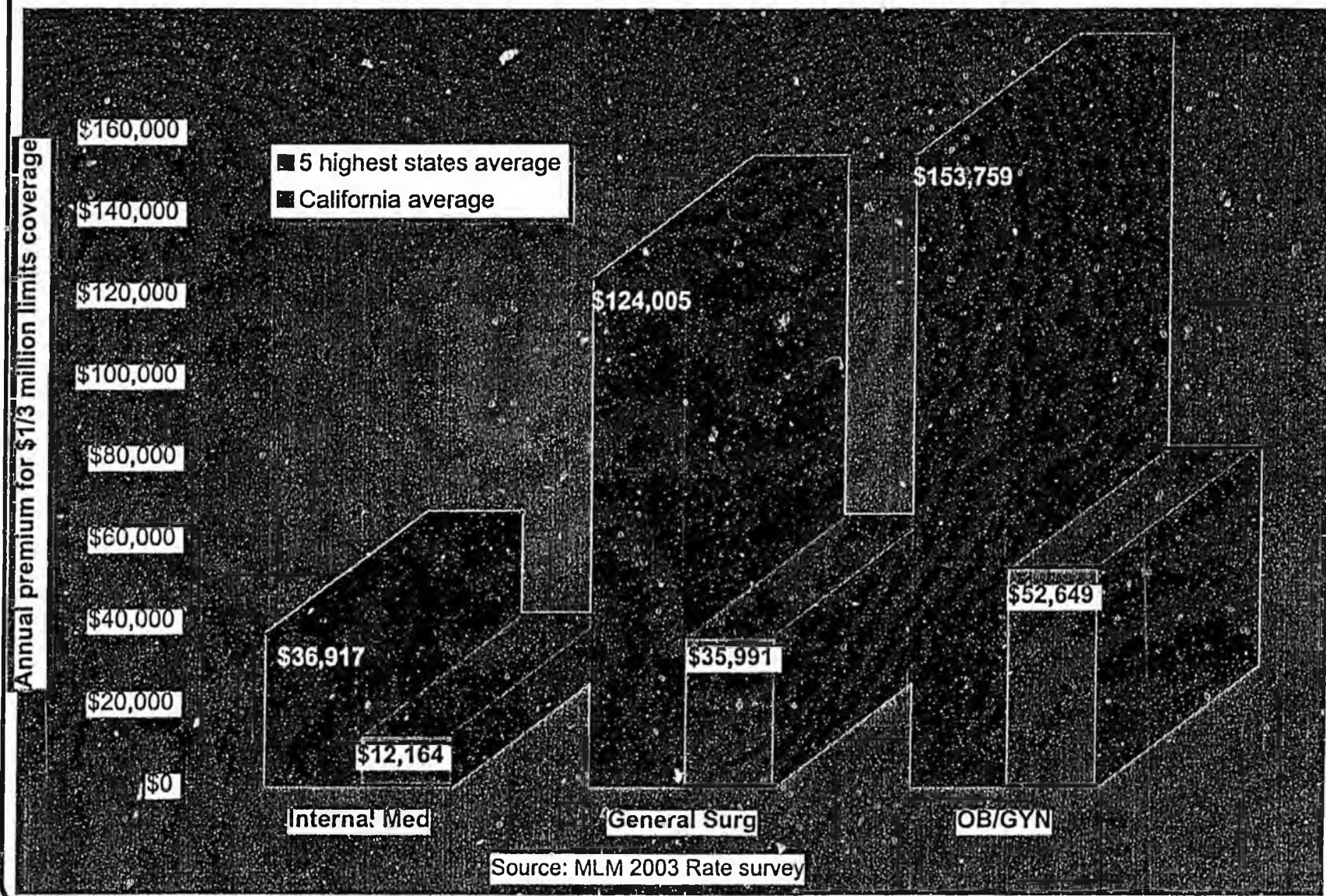
Academy of Actuaries study that indicates that. I think maybe PIAA may have done something as well as some states (Texas, and Pennsylvania?).

Thanks for the help. Also, if you have any other "stuff" that you think would be of help please send it along.

Thanks,
Jim

James Jordan
Executive Director
Alaska State Medical Association
907-562-0304
ASMA@alaska.net

Physician owned insurers malpractice premium comparison - 2003





Milliman USA
Consultants and Actuaries

Contact :
Laura Rzasa, Donley Communications
(212) 751-6126, lrzasa@donleycomm.com

MILLIMAN USA ANALYSIS SEES SAVINGS FOR PROFESSIONAL MEDICAL MALPRACTICE COSTS

Examines Large States Using Caps on Non-Economic Damages

NEW YORK, April 8, 2003: A Milliman USA analysis of medical malpractice claims in the 15 largest states from late 1990 to early 2001 shows wide differences in medical malpractice loss costs by state for physicians, and these differences correlate to whether or not the state has enacted caps on non-economic damages. The study demonstrates that the large states with caps on non-economic damages have below-average medical malpractice loss costs for physicians. Conversely, the large states without caps have the highest medical malpractice costs.

"The data indicate that caps on non-economic damages reduce the cost of insuring medical malpractice for physicians in the states in our study that have instituted this element of tort reform," said Richard S. Biondi, Principal and Consulting Actuary at Milliman USA and the author of the Milliman study. "The study implies that caps on non-economic damages would significantly reduce total losses for both physicians and hospitals."

The data is consistent with results others have observed in California, which is well-known for capping non-economic damages at \$250,000 since 1975. In that state, the medical malpractice losses per physician are about half (52%) of the countrywide average. Other large states in the study that have instituted caps and subsequently have lower medical malpractice losses per physician are: Colorado (69% of the countrywide average), Indiana (86%) and Maryland (64%).

Conversely, large states without caps have higher than average medical malpractice losses per physician. They include: Florida (136% of countrywide average), Illinois (144%), New Jersey (131%), New York (156%), Pennsylvania (171%), and Washington, D.C. (144%).

In a separate 1997 analysis performed by Mr. Biondi using data for New York, which does not have caps, savings were estimated on physicians' medical malpractice losses if caps were instituted. It was projected that caps of \$250,000, \$500,000, \$750,000, and \$1,000,000 would result in a reduction in losses of 29%, 20%, 14% and 11% respectively on policies providing \$1 million to \$3 million coverage for physicians.

press release

"There are other differences between these states besides the fact that they either have or don't have caps, and there are also differences in the size and application of the caps in the states that have them," said Mr. Biondi. "However, the pattern in this particular study is still very clear in showing that caps on non-economic damages are highly correlated to medical malpractice costs."

The data in the Milliman USA study included physicians' statistics by state from the National Practitioners Data Base Public Use Data File (NPDB), which contains selected variables from medical malpractice payment reports on physicians, dentists and other licensed healthcare professionals. A spreadsheet summarizing the results is attached.

Milliman USA, whose corporate offices are in Seattle, serves the full spectrum of business, financial, government and union organizations. Founded in 1947 as Milliman & Robertson, the company has 29 offices in the United States as well as offices in Bermuda, Hong Kong, Japan, Korea, Brazil, and the UK. Milliman USA employs approximately 1,750 people, including a professional staff of over 750 qualified consultants and actuaries. The firm has consulting practices in property and casualty, employee benefits, healthcare and life insurance. It is a founding member of Milliman Global, an international organization of consulting firms serving insurance, employee benefits and healthcare clients worldwide. For further information, visit www.milliman.com.

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NPDB* Loss Data for 15 Largest States and Nationwide

NPDB* Public Use Data File

*NPDB refers to the National Practitioners Data Base

9/1/90-4/30/01

National Claim and Loss Rate per Doctor Reported to the NPDB

(annual losses not trended)

	Doctors (approximate number in 1990)	Annual Loss Per Doctor	Relativity	Status Re Caps (Reference: Aug./Sept. 2002 Medical Liability Monitor)
CA	66,996	2,884	0.52	\$250K cap on non-economic damages.
CO	6,724	3,817	0.69	\$250K cap on non-economic damages. \$1M cap total.
DC	3,068	7,901	1.44	No cap.
FL	26,394	7,508	1.36	No cap for most claims. Caps apply when parties arbitrate.
IL	25,565	7,929	1.44	No cap. Declared unconstitutional.
IN	9,607	4,734	0.86	\$1.25M cap on total damages.
KS	4,673	5,846	1.06	No cap. Declared unconstitutional.
MA	20,089	3,802	0.69	\$500K cap on non-economic damages with exceptions.
MD	15,061	3,503	0.64	\$500K cap on non-economic damages.
MI	18,463	4,347	0.79	\$345K cap on non-economic damages.
NJ	18,765	7,232	1.31	No cap.
NY	56,264	8,610	1.56	No cap.
OH	22,401	6,443	1.17	No cap. Declared unconstitutional.
PA	29,784	9,386	1.71	No cap.
TX	29,004	6,083	1.11	No cap.
All Others	181,034	4,363	0.79	
Total	537,389	5,502		
	533,890			

Milliman USA Study includes physicians' statistics from the NPDB Public Use Data File, which contains selected variables from medical malpractice payment reports on physicians, dentist and other licensed healthcare professionals.

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TRENDS

The Medical Malpractice 'Crisis': Recent Trends And The Impact Of State Tort Reforms

Do recent events constitute a crisis or merely the workings of the insurance cycle?

by Kenneth E. Thorpe

ABSTRACT: By many accounts, the United States is in the midst of its third medical malpractice "crisis." Physicians in several states are facing high and rising premiums. The largest national medical malpractice carrier and some large multistate physician-backed liability firms have recently left the market. Rising premiums are traced largely to increases in claims severity. Capping malpractice payments has been advanced as one approach to slowing the growth in premiums. This analysis finds that premiums in states that cap awards are 17.1 percent lower than in states that don't cap. At issue, however, is whether these stopgap solutions promote the goals of the U.S. liability system.

BY MANY ACCOUNTS, the United States is in the midst of its third "crisis" in medical malpractice. The medical malpractice "crises" in the mid-1970s and 1980s occurred during times of rapid growth in insurance premiums. In the 1970s rising claims frequency and severity resulted in the exit of many malpractice carriers.¹ Some for-profit liability carriers were replaced by a new wave of physician-owned malpractice companies. Medical liability premiums increased sharply again during the 1980s, leading several states to adopt reforms designed to limit malpractice insurers' costs. Indeed, the events of the 1980s led to proposals for broader, more fundamental reforms of the liability system.

Both rising premiums and a reduction in the number of firms offering coverage characterize the most recent medical malpractice crisis. Depending on the specialty and state, the median increase in malpractice premiums ranged from 15 to 30 percent. Rate increases in

other states, such as Pennsylvania, ranged from 26 to 73 percent in 2003.² The St. Paul Companies, the largest insurer throughout most of the 1990s, stopped writing policies during 2002. Other large, regional carriers have also exited the market. Overall, these insurers accounted for nearly 14 percent of the national market prior to the crisis.³ In several states facing the most acute crises, carriers exiting the market accounted for a substantial (up to 40 percent) share of premiums written.

While premiums have risen sharply over the past three years, there is much variation across states. The premium spikes have resulted in physician strikes in West Virginia, work slowdowns in New Jersey, and some temporary closings of hospital services (such as trauma care at the University of Nevada Medical Center). Physicians in other states, such as Connecticut, are staging rallies at their state capitol, demanding "tort" reform. A recent analysis by the American Medical Associ-

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