11896 SENATE LABOR & COMMERCE

Salmon Spawn Rainbow Trout

Scientists in Japan have engineered Asian salmon to produce the eggs and sperm of North American trout, an unprecedented bit of reproductive manipulation that may someday allow researchers to recruit common critters to replenish dwindling endangered species.

The team dissected newly hatched embryos of rainbow trout and removed small batches of "primordial germ cells." Those eventually become eggs or sperm in response to signals they receive from the developing fish.

The researchers, from the Tokyo University of Marine Science and Technology, injected those germ cells into newly hatched Pacific salmon embryos. Some of the cells made their way into the developing ovaries and testes of the recipient salmon, where they matured into rainbow trout eggs and sperm.

A year later, the team collected the milt – the could of sperm that make fish release into the water at maturity – of one of those salmon and mixed it with trout eggs. The result was a crop of purebred baby trout, sired by a salmon. (That salmon also produced salmon sperm, which when mixed with trout eggs created hybrid fish that did not survive.)

Other scientists have transplanted primordial germ cells from one fly species to another and from one bird species to another, resulting in the growth of sperm and eggs of one species inside the sex organs of the other. But the new experiment, described in the Aug. 5 issue of the journal Nature, marks the first such success in fish and the first to create progeny in any species.

Rainbow trout are plentiful, but the technique could help rare species. For example, salmon take one year to become sexually mature while trout take two, suggesting endangered species may be aided through reproductive by faster-breeding species.

-- Rick Weiss

The Seattle Times
seattletimes.com

Tuesday, June 08, 2004, 12:37 A.M. Pacific

Research fuels fear of gene-altered fish

By Sandi Doughton
Seattle Times staff reporter

In a head-to-head battle for food, normal coho salmon lose out to their genetically engineered cousins, says a new study that adds to the controversy over what critics call "frankenfish."

Not only did the aggressive, gene-modified salmon gobble up most of the feed when raised in tanks with ordinary salmon, but they also gobbled up their weaker competitors — including their own type, British Columbia scientists reported in yesterday's online edition of the Proceedings of the National Academy of Sciences.

The results were often dramatic population crashes, with only one or two of the genetically modified fish surviving in tanks that originally held 50 animals, said lead author Robert Devlin of Fisheries and Oceans Canada.

"When food supplies are low, transgenic (genetically modified) fish have a very significant effect on the population," he said, adding the caveat that laboratory experiments may not predict what would happen if bioengineered salmon escaped into the environment.

But that's a question that needs to be answered soon.

Massachusetts-based Aqua Bounty Farms has asked the U.S. Food and Drug Administration for approval to market what could be the first transgenic food fish: Atlantic salmon that grow twice as fast as normal fish. Aqua Bounty hopes to raise its transgenic salmon in coastal net pens in the United States and market the eggs around the world, said Joseph McGonigle, vice president for external affairs. "We are constantly hearing from companies that are interested in it," he said.

Faster-growing salmon would cut costs dramatically for fish farmers and lead to lower prices in the supermarket, McGonigle said.

Consumer groups, commercial fishermen and some scientists say studies such as Devlin's show the potential ecological consequences of unleashing man-made breeds of fish.

"We should not be taking a risk like this at a time when native salmon stocks are already in trouble," said Doug Gurian-Sherman, senior scientist at the Center for Food Safety, a consumer group based in Washington, D.C.

enlarge STEVE RINGMAN / THE SEATTLE T. IES

Although gene-modified fish grow much faster than normal coho salmon, they don't get much bigger at maturity, research.. s say.

A 2002 National Academy of Sciences report expressed moderate concern that genetically engineered fish might pose risks to consumers if, for example, a person who was allergic to scallops ate fish with a scallop gene spliced into its DNA. But experts agreed that the biggest danger is that some of the gene-modified fish would inevitably escape into the environment.

Hundreds of thousands of Atlantic salmon have escaped into Northwest waters from salmon farms over the past several years when floating pens were ripped apart by storms or marauding sea lions.

The worst-case scenario involving transgenic fish is the "Trojan gene" hypothesis proposed by Purdue University geneticist William Muir: Genetically engineered salmon outcompete normal fish for food and mates, leading to less-hardy hybrids and the eventual extinction of the entire wild population.

McGonigle says the net pens would hold only sterile females, eliminating the possibility that escapees could breed in the wild. Several other studies, including some in Devlin's lab, have shown that the genetically engineered fish aren't likely to survive well outside of captivity because they're more susceptible to disease and oblivious to predators.

"We realize we have no chance of getting approval unless we can clearly demonstrate these fish are completely sterile, and they represent no genetic threat and no behavioral threat, in terms of competition for resources," he said.

Washington's Fish and Wildlife Commission banned genetically engineered fish from marine net pens, but the state has no rules that bar them from land-based tanks or fresh water, said John Kerwin, who manages the state's hatchery program. Oregon has similar restrictions, while California bans the creatures entirely — including the fluorescent Glo Fish, a genetically engineered aquarium fish that went on sale last year.

Devlin's research for the Canadian government is attempting to unravel the possible impacts of genetically engineered food fish before they're approved.

"We're just starting to gather the kinds of laboratory information which we hope will provide us with understanding about these animals," he said.

He works with coho salmon that overproduce growth hormone as a result of genetic tinkering. Aqua Bounty's Atlantic salmon were engineered in a similar way, using genes from chinook salmon and a species called ocean pout.

In both cases, the genetically engineered fish grow much faster than ordinary fish but don't get much bigger at maturity.

At 1 year of age, Devlin's gene-engineered fish are 10 times the size of ordinary coho.

For the study reported yesterday, Devlin and his colleagues manipulated the amount of food available to the fish. When food was abundant, normal and genetically modified fish coexisted well. It was only when

food was scarce that competition turned deadly for the normal fish.

While populations made up only of normal fish were able to ride out food shortages, mixed populations invariably crashed.

But the experiments also revealed another wrinkle: Populations made up of only genetically engineered fish also crashed when food supplies were low.

Does that mean transgenic fish might pose little risk if they escaped into the environment because they would die out when food supplies drop?

It's possible, Devlin said.

"If you had a small population, where the fish couldn't migrate out of the area, transgenic fish might eat themselves out of house and home and there would be no risks," he said.

But on the other hand, if numbers boomed when food was plentiful, the bioengineered fish could devastate normal fish in the cutthroat competition that would ensue.

McGonigle says he hopes to have an FDA ruling within the next two years, but the target date has been pushed back repeatedly.

Because of regulations to protect businesses, the agency's evaluation process is largely secret, leading critics to call for a new system that is open and gives more authority to environmental and wildlife agencies.

"FDA has absolutely no experience with these kinds of issues," said Gurian-Sherman, the Center for Food Safety scientist. "And we know nothing about what they're doing."

Sandi Doughton: 206-464-2491 or sdoughton@seattletimes.com

GLOBEANDMAIL.COM

Print this Page

Both sides in fight over genetically modified fish are hoping this big one does not get away

By MARK HUME

UPDATED AT 2:21 PM EST

Friday, Dec 10, 2004

VANCOUVER -- They are swimming lazily in a few fish tanks right now, but Atlantic salmon that were developed in Canada may soon be the focus of the next big fight over genetically modified food.

To critics, the salmon designed to grow up to six times as fast as ordinary farmed salmon, are freaks of nature -- Frankenfish that shouldn't be allowed out of the lab.

Proponents say they're a remarkable creation that will help feed an increasingly hungry world and can reduce the environmental impact of fish farming by producing bigger fish, in less time, with less food.

"There's no question that this is the way things will go . . . this is the way salmon and many other fish will be grown in the future," Joseph McGonigle, the vice-president of Aqua Bounty Technologies, said yesterday.

His company, which has offices in the United States and Canada, has developed a fish that has trademark protection. Aqua Bounty has applied to the U.S. Food and Drug Administration for approval to market the salmon and is preparing to make a similar application in Canada, perhaps next year.

The first genetically modified fish approved in North America appeared on the market last year. The GloFishtm, a pet that glows in the dark, was cleared for sale in the United States with little opposition. Some shipments were made to Canada but have stopped pending a review by Environment Canada.

But the AquAdvantage salmon is a more complicated product; it is meant for human consumption, and it could survive in the wild.

"If these salmon get into fish farms, it will only be a matter of time before they get out," the Sierra Club's Vicky Husband said. "All you need is to have one escape and then they are interbreeding with the wild populations. It's horrific. We say absolutely no way to these fish."

Theresa Rothenbush of the Raincoast Conservation Society, said "consumers would be in shock if this fish was to ever get to market."

Mr. McGonigle said much of the criticism he hears is unfair and the Frankenfish label makes him bristle. "It's just silly. This is professional spin-doctoring going on."

AquAdvantage salmon are like any other Atlantic salmon, except for the genetic change that allows them to grow more rapidly, he said.

Has he ever eaten one?

"I have. I've had them smoked. They are absolutely indistinguishable from any other farmed fish. . . . They are perfectly good-looking fish. I mean they are normal."

The AquAdvantage salmon were developed by Canadian scientists trying to help farmed Atlantic salmon survive winter. Those experiments, which involved introducing fish anti-freeze protein genes into Atlantic salmon from flounders, led to a growth breakthrough when genes from Chinook salmon (a Pacific species) and pout (a type of cod) were introduced.

In the early stages of life, the AquAdvantage salmon grow four to six times as fast as unaltered fish. They then slow down and approach the normal rate of growth. The early growth spurt could allow fish farmers to get fish to market size in 18 months rather than 36 months.

AquAdvantage salmon are found only in experimental fish tanks in the company hatchery in Prince Edward Island and at Memorial University in Newfoundland. A similar type of genetically modified salmon is also under study in a federal government lab in Vancouver.

SB

42

SENATE COMMITTEE REPORT
First Committee of Referral

TE: 1/11/05

FURTHER: Finance

le of 5-Day Notice: _____
accordance with Uniform Rule 23)

DATE TURNED
IN TO OFFICE: _____

or and Commerce Committee considered SENATE BILL NO. 42

SB 42 NATUROPATHIC MEDICINE TASK FORCE

Act extending the reporting date for and the termination date of the Task Force on Naturopathic Scope of ctice; and providing for an effective date."

recommends:

be **replaced** with _____ **CS** _____ (_____)

adopt **previous** _____ **CS** _____ (_____)

attached amendment(s)

adopt Letter of Intent by _____ Committee

further referral to _____ Committee

Senate Bill:
[ ] Same Title
[ ] New Title

House Bill:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

W FISCAL NOTE(S):

artment	Date	Fiscal	Indet.	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

APPROPRIATION - no fiscal note

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
			X	
Ralph Seekins	X			
Ben Stevens	✓			
HAIR: C. Brent	✓			

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

January 26, 2005

Honorable Con Bunde
Chair, Senate Labor and Commerce Committee
State Capitol, Room 506
Juneau, AK 89801-1182

Transmitted by fax:
907-465-3871

Re: SB 42 – Task Force on Naturopathic Scope of Practice

Dear Senator Bunde:

The Alaska State Medical Association (ASMA) represents physicians from across the State and is primarily concerned with the health care for Alaska's patients. ASMA thanks you for the opportunity to provide testimony on SB 42.

ASMA is represented on the Naturopathic Scope of Practice Task Force and supports the extension of the report date to December 1, 2005 and the extension of the "sunset" date to February 1, 2006. Furthermore, ASMA supports the concept of the process exemplified by the Naturopathic Scope of Practice Task Force; and would suggest that the process might serve as a template for future Legislative reviews of requests for expanded scopes of practices for various non-physician health care providers. Meaningful and objective analysis must be accomplished to provide for the public's safety.

Please let me know if I may be of any further assistance. ASMA urges you and the entire Labor and Commerce Committee to support SB 42.

Sincerely,

Paul Worrell, MD

By: Paul Worrell, MD President
For: The Alaska State Medical Association

cc: Senator Ralph Seekins
Senator Ben Stevens
Senator Johnny Ellis
Senator Bettye Davis

ALASKA STATE SENATE

Session:
State Capitol
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(907) 465-2327
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Interim:
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Fairbanks, Alaska 99701
(907) 456-8161
Senator_Ralph_Seekins@legis.state.ak.us

Senator Ralph Seekins
District D

Senate Bill 42 Sponsor Statement

"An Act extending the reporting date for and the termination date of the Task Force on Naturopathic Scope of Practice."

During the 23rd Legislative session SB 306 established a task force to examine various elements and aspects relating to naturopathic physicians' scope of practice. By statute the task force was charged with addressing:

1. comparable educational and training levels of naturopaths and medical doctors;
2. the use of legend or prescription drugs by naturopaths with respect to scope of practice;
3. non-pharmacological treatments by naturopaths including minor surgery;
4. collaborative protocols and agreements between naturopaths and medical doctors;
5. joint liability issues between collaborating practitioners; and,
6. other issues of relevance.

SB 306 established that the task force would consist of nine voting members. These are as follows:

1. Alex Malter, MD representing the Alaska State Medical Association;
2. Richard Holm, RPh representing the Alaska Pharmacist Association;
3. Robert Breffeilh, MD representing the Alaska State Medical Board;
4. Cathy Giessel, MSN FNP-CS representing Nurse Practitioners;
5. Jason Harmon, ND representing licensed Naturopaths;
6. Scott Luper, ND representing licensed Naturopaths;
7. Rick Urion, Director of the Division of Occupational Licensing;
8. Lesil McGuire, Alaska State Representative for District 28; and,
9. Ralph Seekins, Alaska State Senator for District D.

The task force was unable to complete its business within the time parameters specified in SB 306. Consequently, SB 42 extends the task force's charge into 2005. In fact, SB 42 is identical to the previous bill except for the report and termination dates which have been changed to December 1, 2005 and February 1, 2006, respectively.

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 42
() Publish Date:

Revision Date/Time (Note if correction):
Title: Naturopathic Medicine Task Force
Dept. Affected: Commerce
RDU: Occupational Licensing (117)
Component: Occupational Licensing
Sponsor: Seekins
Requester: Senate Labor and Commerce
Component No.: 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0					
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )	0.0					

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other 1156 - Receipt Supported Services						
TOTAL	0.0					

Estimate of any current year (FY2005) cost: 0 0
Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

Ths legislation establishes in the legislative branch a Task Force on Naturopathic Scope of Practice The Task Force is terminated on February 1, 2006 New funds are not required by the department to implement this bill.

Prepared by: Jennifer Strickler, Administrative Manager
Phone: (907) 465-2144
Division: Occupational Licensing
Date/Time: 1/21/05 6:12 PM
Approved by: Edgar Blatchford, Commissioner
Date: 1/21/2005
Agency: Commerce, Community & Economic Development

(Revised 12/2003 OMB)

SB

52

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/12/05

FURTHER:

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED
IN TO OFFICE: _____

Labor and Commerce Committee considered SENATE BILL NO. 52

SB 52 OCCUPATIONS/CORPORATIONS/BANKS/SECURITIES

"An Act relating to the reorganization of certain functions of the division of banking, securities, and corporations and the division of occupational licensing in the Department of Commerce, Community, and Economic Development; and providing for an effective date."

and recommends:

[ ] be **replaced** with _____ **CS** _____ (_____)

[ ] adopt **previous** _____ **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to _____ Committee

Senate Bill:
[ ] Same Title
[ ] New Title

House Bill:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #_____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
			X	
	✓			
CHAIR:	✓			

FOR SB 52

did not adopt for final passage offered by Division of Occupational Licensing - not needed according to legal

Proposed Amendment

Page 2 line 25 through page 3 line 6 delete Se. 4 and insert a new Sec. 4 to read:

- Sec. 4. AS 08.32.071 is amended to read:

Sec. 08.32.071. Renewal of registration. At least 60 days before expiration of a licensee's registration certificate, the **department** [DIVISION OF OCCUPATIONAL LICENSING] shall mail a form for renewal of registration to each licensed dental hygienist. Each licensee who wishes to renew a registration certificate shall complete the form and return it with the appropriate fee and evidence of continued professional competence as required by the board. The **department** [DIVISION OF OCCUPATIONAL LICENSING] shall, as soon as practicable, issue a registration certificate valid for a stated number of years. Each licensee shall keep the registration certificate beside or attached to the licensee's licensee. Failure to receive the registration form does not exempt a licensee from renewing registration.

Page 7 lines 2-4 delete Sec. 14 and insert new Sec. 14 to read:

- Sec. 14 AS 08.45.200 is repealed and reenacted to read:

(1) "controlled substance" has the meaning given in AS 11.71.900;

(2) "department" means the Department of Commerce, Community, and Economic Development;

(3) "naturopathy" means the use of hydrotherapy, dietetics, electrotherapy, sanitation, suggestion, mechanical and manual manipulation for the stimulation of

physiological and psychological action to establish a normal condition of mind and body; in this paragraph, 'dietetics" includes herbal and homeopathic remedies.

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 2, 2005

SUBJECT: CSSB 52(L&C), relating to the functions of the Division of Banking, Securities, and Corporations
(Work Order No. 24-GS1053\G)

TO: Senator Con Bunde
Attn: Jane

FROM: Theresa Bannister
Legislative Counsel

This memo accompanies a draft of the bill identified above. You have requested that I identify the changes that we have made to this bill.

1. Title. A clause has been added to the title to provide notice of two provisions. The phrase, "the reorganization of," has been deleted because, although the purpose apparently is to allow for reorganization, the actual terms of the bill do not speak of reorganization, and the amendment of AS 10.13.810(b) is not for the purpose of reorganization (according to the Governor's transmittal letter).

2. AS 08.45.070(c). In the second sentence, "no" has been changed to "not".

3. AS 18.18.100(n). The references to the Department of Commerce, Community, and Economic Development have been changed by using "department," providing a definition of "department," and replacing "that department" with "the department."

4. AS 08.24.26 and AS 10.20.530. Commas have been added.

5. AS 37.05.146(c)(34). The language of this paragraph has been reworded to improve its syntax.

6. AS 40.25.110(e). The amendments in this subsection have been reworded to improve the syntax.

7. Section 25 was rewritten in order to avoid problems if the effective date of sec. 14, ch. 163, SLA 2004 were changed in another bill.

8. AS 08.26.180. This section refers to "the division in the department that regulates banking, securities, and corporations." Do you want this section amended as well? The draft currently amends AS 37.05.146(c)(24), which contains the same type of language.

If I may be of further assistance, please advise.

TLB:med
05-077.med

Enclosure

24-GS1053\F
Bannister
2/4/05

CS FOR SENATE BILL NO. 52(L&C)

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-FOURTH LEGISLATURE - FIRST SESSION

BY THE SENATE LABOR AND COMMERCE COMMITTEE

Offered:
Referred:

Sponsor(s): SENATE RULES COMMITTEE BY REQUEST OF THE GOVERNOR

A BILL

FOR AN ACT ENTITLED

"An Act relating to certain functions of the division of banking, securities, and corporations and the division of occupational licensing in the Department of Commerce, Community, and Economic Development; relating to program receipts and record search fees of the Department of Commerce, Community, and Economic Development related to banking, securities, and corporations; and providing for an effective date."

BE IT ENACTED BY THE LEGIS. \TURE OF THE STATE OF ALASKA:

*** Section 1.** AS 08.13.215(c) is amended to read:

(c) The owner of a shop for tattooing and permanent cosmetic coloring or for body piercing shall prominently display

(1) a copy of the statement provided by the board under AS 08.13.030(b) that advises the public of the health risks and possible consequences of tattooing and permanent cosmetic coloring or body piercing, as applicable;

(2) the names, addresses, and telephone numbers of the [DIVISION

OF OCCUPATIONAL LICENSING,] Department of Commerce, Community, and Economic Development [,] and the Department of Environmental Conservation and a description of how a complaint about the shop or a practitioner in the shop may be filed with either entity or with the board.

*** Sec. 2.** AS 08.24.260 is amended to read:

Sec. 08.24.260. Investigations. The department may, upon its own motion, and shall, upon the sworn complaint in writing of a customer of a collection agency, investigate the actions of a licensee claimed to have violated this chapter and, for that purpose, shall have free access to the offices and place of business and, if the complaint involves customer accounts, to all pertinent books, accounts, records, papers, files, safes, and vaults of the licensee or certificate holder. If the complaint involves the owing of money, or any other thing of value, by a licensee to the complainant, when the licensee raises the issue of an offset or counterclaim, the **department** [DIVISION] may require the complainant to submit all records and data in the complainant's possession pertaining to the offset or counterclaim.

*** Sec. 3.** AS 08.26.180 is amended to read:

Sec. 08.26.180. Exemption. A financial institution regulated by the federal government or a financial institution regulated under AS 06 by the [DIVISION IN THE] department [THAT REGULATES BANKING, SECURITIES, AND CORPORATIONS,] is not required to be licensed under this chapter in order to engage in the business of providing services as a guardian or a conservator or be appointed as a private professional guardian or a private professional conservator by a court. In this subsection, "financial institution" does not include a person who is exempt under AS 06.26.020 or who has received an exemption under AS 06.26.200.

*** Sec. 4.** AS 08.32.071 is amended to read:

Sec. 08.32.071. Renewal of registration. At least 60 days before expiration of a licensee's registration certificate, the **Department of Commerce, Community, and Economic Development** [DIVISION OF OCCUPATIONAL LICENSING] shall mail a form for renewal of registration to each licensed dental hygienist. Each licensee who wishes to renew a registration certificate shall complete the form and return it with the appropriate fee and evidence of continued professional competence

as required by the board. The **Department of Commerce, Community, and Economic Development** [DIVISION OF OCCUPATIONAL LICENSING] shall, as soon as practicable, issue a registration certificate valid for a stated number of years. Each licensee shall keep the registration certificate beside or attached to the licensee's license. Failure to receive the registration form does not exempt a licensee from renewing registration.

*** Sec. 5.** AS 08.36.190 is amended to read:

Sec. 08.36.190. Grading of examination. Upon the conclusion of the written examination and as soon as practicable, the papers shall be rated by an examiner. The examiner shall prepare a report in duplicate on each written examination and a report in duplicate on each practical examination. The examiner shall forward one copy of each report on each candidate to the secretary of the board and one copy to the **department** [DIVISION OF OCCUPATIONAL LICENSING]. The secretary shall prepare a composite report on each applicant and file one copy of that report with the **department** [DIVISION OF OCCUPATIONAL LICENSING]. As soon as practicable, the **department** [DIVISION OF OCCUPATIONAL LICENSING] shall notify each candidate of the results of the examination.

*** Sec. 6.** AS 08.36.230 is amended to read:

Sec. 08.36.230. Practice outside the state. A dentist licensed to practice in this state and residing and practicing dentistry outside this state may maintain eligibility to practice in this state by registering the dentist's name and place of residence with the **department** [DIVISION OF OCCUPATIONAL LICENSING] every four years and submitting proof of continued professional competence as required by the board. If the dentist fails to register, the board may reinstate the dentist's license without examination upon payment of applicable fees established by regulations adopted under AS 08.01.065, payment of a penalty established under AS 08.01.100(b), presentation of proof of continued professional competence, and presentation of proof of active practice certified by the dental board having jurisdiction or, if there is no board with jurisdiction, by evidence satisfactory to the board.

*** Sec. 7.** AS 08.36.250(a) is amended to read:

(a) At least 60 days before expiration of a licensee's registration certificate, the **department** [DIVISION OF OCCUPATIONAL LICENSING] shall mail a form for renewal of registration to each licensed dentist. A licensee who wishes to renew a license shall complete the form and return it with the appropriate fee and evidence of continued professional competence as required by the board. The **department** [DIVISION OF OCCUPATIONAL LICENSING] shall, as soon as practicable, issue a registration certificate valid for a stated number of years. A licensee shall keep the registration certificate beside or attached to the licensee's license. Failure to receive the registration form does not exempt a licensee from renewing registration.

*** Sec. 8.** AS 08.45.020 is amended to read:

Sec. 08.45.020. Application for license. A person desiring to practice naturopathy shall apply in writing to the **department** [DIVISION OF OCCUPATIONAL LICENSING OF THE DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT].

*** Sec. 9.** AS 08.45.030 is amended to read:

Sec. 08.45.030. Issuance of license. The **department** [DIVISION] shall issue a license to practice naturopathy to an applicant who provides proof satisfactory to the **department** [DIVISION] that the applicant has received a degree from an accredited four-year college or university, and

(1) on or before December 31, 1987, has graduated from a school of naturopathy that required four years of attendance at the school and after graduation has received a license in another state after passing an examination for licensure in that state and is licensed by a state at the time of application; or

(2) after December 31, 1987, has

(A) graduated from a school of naturopathy that required four years of attendance at the school and at the time of graduation the school was accredited or a candidate for accreditation by the Council on Naturopathic Medical Education or a successor organization recognized by the United States Department of Education and

(B) passed the Naturopathic Physicians Licensing Examination.

*** Sec. 10.** AS 08.45.035(a) is amended to read:

(a) The **department** [DIVISION] shall issue a temporary license to practice naturopathy to an applicant who has applied for and is qualified to take the next Naturopathic Physicians Licensing Examination offered after the date of application and provides proof satisfactory to the **department** [DIVISION] that the applicant

(1) meets the requirements of AS 08.45.030(2)(A); and

(2) has not previously failed the Naturopathic Physicians Licensing Examination.

*** Sec. 11.** AS 08.45.060 is amended to read:

Sec. 08.45.060. Grounds for suspension, revocation, or refusal to issue a license. The **department** [DIVISION] may, after a hearing, impose a disciplinary sanction on a person licensed under this chapter when the **department** [DIVISION] finds that the licensee

(1) secured a license through deceit, fraud, or intentional misrepresentation;

(2) engaged in deceit, fraud, or intentional misrepresentation in the course of providing professional services or engaging in professional activities;

(3) advertised professional services in a false or misleading manner;

(4) has been convicted of a felony or other crime that affects the licensee's ability to continue to practice competently and safely;

(5) failed to comply with this chapter, with a regulation adopted under this chapter, or with an order of the **department** [DIVISION];

(6) continued to practice after becoming unfit due to

(A) professional incompetence;

(B) addiction or severe dependency on alcohol or a drug that impairs the licensee's ability to practice safely;

(C) physical or mental disability;

(7) engaged in lewd or immoral conduct in connection with the delivery of professional service to patients.

*** Sec. 12.** AS 08.45.070 is amended to read:

Sec. 08.45.070. Disciplinary sanctions. (a) When it finds that a licensee under this chapter has violated AS 08.45.040 - 08.45.050 or is guilty of an offense

under AS 08.45.060, the **department** [DIVISION] may impose the following sanctions singly or in combination:

(1) permanently revoke the license to practice;

(2) suspend the license for a determinate period of time;

(3) censure the licensee;

(4) issue a letter of reprimand to the licensee;

(5) place the licensee on probationary status and require the licensee to

(A) report regularly to the **department** [DIVISION] upon matters involving the basis of probation;

(B) limit practice to those areas prescribed;

(C) continue professional education until a satisfactory degree of skill has been attained in areas determined by the **department** [DIVISION] to need improvement;

(6) impose limitations or conditions on the practice of the licensee.

(b) The **department** [DIVISION] may withdraw probationary status of a licensee if it finds that the deficiencies that required the sanction have been remedied.

(c) The **department** [DIVISION] may summarily suspend a license before final hearing or during the appeals process if the **department** [DIVISION] finds that the licensee poses a clear and immediate danger to the public health and safety if the licensee continues to practice. A licensee whose license is suspended under this section is entitled to a hearing by the **department not** [DIVISION NO] later than seven days after the effective date of the order. The licensee may appeal the suspension after a hearing to a court of competent jurisdiction.

*** Sec. 13.** AS 08.45.070(c), as amended by sec. 14, ch. 163, SLA 2004, is further amended to read:

(c) The **department** [DIVISION] may summarily suspend a license before final hearing or during the appeals process if the **department** [DIVISION] finds that the licensee poses a clear and immediate danger to the public health and safety if the licensee continues to practice. A licensee whose license is suspended under this section is entitled to a hearing conducted by the office of administrative hearings (AS 44.64.010) not later than seven days after the effective date of the order. The

licensee may appeal the suspension after a hearing to a court of competent jurisdiction.

*** Sec. 14.** AS 08.45.200 is amended by adding a new paragraph to read:

(4) "department" means the Department of Commerce, Community, and Economic Development.

*** Sec. 15.** AS 08.64.050 is amended to read:

Sec. 08.64.050. Oath of office. Each member shall take an oath of office. The oath shall be filed and preserved in the [DIVISION OF OCCUPATIONAL LICENSING OF THE] department.

*** Sec. 16.** AS 10.13.810(b) is amended to read:

(b) The department may appoint as conservator one of the employees of the [DIVISION OF BANKING, SECURITIES, AND CORPORATIONS OF THE] department or another competent and disinterested person. The **department** [DIVISION] shall be reimbursed out of the assets of the conservatorship for all money expended by the **department** [DIVISION] in connection with the conservatorship. Upon the approval of the department, the expenses of the conservatorship , aid for by the **department** [DIVISION] shall be paid out of the assets of the licensee. Payment of the **department** [DIVISION] expenses shall take priority over other payments from the assets and shall be fully paid before a final distribution is made.

*** Sec. 17.** AS 10.20.530 is amended to read:

Sec. 10.20.530. Service on commissioner. When a foreign corporation authorized to transact business in the state, or not authorized to transact business in the state but doing so, fails to appoint or maintain a registered agent in the state, or when a registered agent cannot with reasonable diligence be found at the registered office, or when the certificate of authority of a foreign corporation is suspended or revoked, the commissioner is an agent upon whom process, notice, or demand may be served. Service on the commissioner shall be made by delivering to and leaving with the commissioner, or **the commissioner's** [A] designee [IN THE CORPORATION DIVISION OF THE DEPARTMENT], duplicate copies of the process, notice, or demand, accompanied by a fee established by the department by regulation. The commissioner shall immediately have one copy forwarded by registered or certified mail, addressed to the corporation at its principal office in the state or country under

whose laws it is incorporated. Service on the commissioner is returnable in not less than 30 days.

*** Sec. 18.** AS 13.36.145(b) is amended to read:

(b) The separate fund of securities required by (a)(2) of this section shall be marked as a separate fund for (a)(2) of this section. Withdrawals from or additions to the separate fund may be made from time to time, as long as the required value is maintained. The income of the securities in the separate fund belongs to the corporate trustee. In the statements of its financial condition published or delivered to the [DIVISION OF BANKING, SECURITIES, AND CORPORATIONS IN THE] Department of Commerce, Community, and Economic Development, the corporate trustee shall show as separate items the amount of trust funds that it has deposited with itself and the amount of securities that it holds as security for the payment of the deposits.

*** Sec. 19.** AS 18.18.100(n) is amended to read:

(n) A hospice program may not use a direct service provider whose name is listed on an abuse registry maintained by the **department** [DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT, DIVISION OF OCCUPATIONAL LICENSING]. A hospice program shall contact **the department** [THE DIVISION] for a determination of whether a prospective direct service provider's name is on an abuse registry maintained by **the department** [THE DIVISION] and may not allow the person to provide hospice services until **the department** [THE DIVISION] has responded to the inquiry. The **department** [DEPARTMENT OF COMMERCE, COMMUNITY, AND ECONOMIC DEVELOPMENT] may adopt regulations to implement this subsection. **In this subsection, "department" means the Department of Commerce, Community, and Economic Development.**

*** Sec. 20.** AS 34.80.090(4) is amended to read:

(4) "financial institution" means a financial institution

(A) whose accounts are insured by an agency of the federal government;

(B) that is located in this state and does not meet the

requirements of (A) of this paragraph, but is subject to regulation by the [DIVISION OF BANKING, SECURITIES AND CORPORATIONS IN THE] Department of Commerce, Community, and Economic Development; or

(C) that is located in another state and does not meet the requirements of (A) of this paragraph, but is subject to regulation in the other state by an agency comparable to the [DIVISION OF BANKING, SECURITIES AND CORPORATIONS IN THE] Department of Commerce, Community, and Economic Development;

*** Sec. 21.** AS 37.05.146(c)(34) is amended to read:

(34) receipts of the [DIVISION OF THE] Department of Commerce, Community, and Economic Development **from its functions relating to** [THAT REGULATES] banking, securities, and corporations;

*** Sec. 22.** AS 40.25.110(e) is amended to read:

(e) Notwithstanding other provisions of this section to the contrary, the Bureau of Vital Statistics and the library archives in the Department of Education and Early Development may continue to charge the same fees that they were charging on September 25, 1990, for performing record searches, and may increase the fees as necessary to recover agency expenses on the same basis that was used by the agency immediately before September 25, 1990. Notwithstanding other provisions of this section to the contrary, the [DIVISION OF BANKING, SECURITIES, AND CORPORATIONS IN THE] Department of Commerce, Community, and Economic Development may continue to charge the same fees that the former Department of Commerce and Economic Development was charging on July 1, 1999, for performing record searches **for matters related to banking, securities, and corporations,** and may increase the fees as necessary to recover agency expenses on the same basis that was used by the former Department of Commerce and Economic Development immediately before July 1, 1999.

*** Sec. 23.** AS 46.03.375(a) is amended to read:

(a) The department shall adopt regulations governing the certification of persons who install, test, close, repair, or significantly change the configuration of underground petroleum storage tanks and tank systems. The certification program

shall be administered by the [DIVISION OF OCCUPATIONAL LICENSING,] Department of Commerce, Community, and Economic Development. In consultation with the Department of Environmental Conservation, the **Department of Commerce, Community, and Economic Development** [DIVISION] shall make every reasonable attempt to ensure that opportunities for obtaining certification under this section are available throughout the state. The **Department of Commerce, Community, and Economic Development** [DIVISION] shall organize presentation of national training courses that are available in the state and assist residents of isolated communities who request assistance in becoming certified. The **Department of Commerce, Community, and Economic Development** [DIVISION] may contract with the University of Alaska, a vocational technical school, or a regional nonprofit organization to provide the education and testing necessary for certification.

*** Sec. 24.** AS 46.03.375(b) is amended to read:

(b) The **Department of Commerce, Community, and Economic Development** [DIVISION] shall establish fees applicable to certification under this section in an amount necessary to cover the costs of the certification program. The fees shall be collected by the **Department of Commerce, Community, and Economic Development** [DIVISION].

*** Sec. 25.** AS 08.45.200(2) and AS 46.03.375(g)(2) are repealed.

*** Sec. 26.** Section 13 of this Act takes effect on the effective date of sec. 14, ch. 163, SLA 2004.

*** Sec. 27.** Except as provided in sec. 26 of this Act, this Act takes effect immediately under AS 01.10.070(c).

GOVERNOR'S TRANSMITTAL LETTER SB52

FRANK H. MURKOWSKI
GOVERNOR

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STATE OF ALASKA
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January 11, 2005

The Honorable Ben Stevens
President of the Senate
Alaska State Legislature
State Capitol, Room 111
Juneau, AK 99801-1182

Dear President Stevens:

Under the authority or art. III, sec. 18, of the Alaska Constitution, I am transmitting a bill relating to the reorganization of certain business functions in the Department of Commerce, Community, and Economic Development (department).

This bill would make statutory changes needed to fully effectuate my Administrative Order No. 219, issued September 17, 2004. The purpose of that Order, and this bill, is to further a coordinated, "one-stop shopping" environment for establishing corporations, limited liability companies, and other business entities, for registering and reserving business names, and for obtaining business and occupational licenses. Under the Order, almost all "corporations" functions were moved from the Division of Banking, Securities, and Corporations to the Division of Occupational Licensing in the department. To reflect this reorganization in the statutes, the bill would substitute "department" for references to the two specific divisions. These amendments also will allow the commissioner of the department future latitude in assigning duties and functions within the department, including renaming divisions to more accurately reflect their current objectives.

Under the Order and this bill, duties related to the Alaska BIDCO Act under AS 10.13 and required statements of financial conditions of business entities would not be moved to the division of occupational licensing, although references in AS 10.13 to the Division of Banking, Securities, and Corporations would be changed by the bill to refer to the department rather than the currently named division.

I urge your prompt and favorable action on this measure.

Sincerely yours,

Frank H. Murkowski
Governor

Enclosure

COMMITTEE COPY

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number: 1
Bill Version: SB 52
(S) Publish Date: 1/12/05

Revision Date/Time (Note if correction):
Dept. Affected: Commerce
Title: Reorganize Corporations Functions
RDU: Occupational Licensing (117)
Component: Occupational Licensing
Sponsor: Rules
Requester: By Request of the Governor
Component No.: 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES ( )						

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
Other (Specify Type--Do not abbreviate)						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2005) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This legislation changes references to divisions that perform functions for forming business entities and makes them the responsibility of the department. There is no fiscal impact as a result of this legislation.

Prepared by: Jennifer Strickler, Administrative Manager
Phone: 907.465.2144
Division: Division of Occupational Licensing
Date/Time: 12/3/04 4:33 PM
Approved by: Edgar Blatchford, Commissioner
Date: 12/3/2004
Agency: Department of Commerce

(Revised 9/23/2004 OMB)

Frank H. Murkowski
GOVERNOR

STATE OF ALASKA
OFFICE OF THE GOVERNOR
JUNEAU

September 17, 2004

ADMINISTRATIVE ORDER NO. 219

Under the authority of art. III, secs. 1, 23, and 24 of the Alaska Constitution, and AS 44.17.020, I order the following changes in the organization of the functions, programs, and staff concerning specified business activities regarding corporations and other business entities administered by the Department of Commerce, Community, and Economic Development:

1. **PURPOSE; GOAL.** The purpose of this Order is to streamline and centralize certain activities of the Department of Commerce, Community, and Economic Development (department) concerning the formation of corporations, limited liability companies, and other business entities in order to foster their development and to further a coordinated approach by the department to these activities. The goal of this Order is to further, within one division of the department, "one-stop shopping" for (1) legally forming business entities, including corporations and limited liability companies; (2) registering trademarks; (3) obtaining necessary business licenses; and (4) securing any required occupational licenses or certificates.

2. **CHANGE OF STAFF REPORTING ASSIGNMENTS.** Department staff assigned to the corporations section in the division of banking, securities, and corporations in the department are transferred to the division of occupational licensing in the department and will report to the director of the division of occupational licensing. With the transfer, staff will remain in the classified service.

3. **REORGANIZATION OF BUSINESS ENTITY FUNCTIONS.** The commissioner of the department is authorized and ordered to implement the reorganization of certain business entity functions of the department, as follows:

a. all functions assigned to the corporations section of the division of banking, securities, and corporations, except for duties related to the Alaska BIDCO Act under AS 10.13 and required statements of financial conditions of business entities, are transferred to the division of occupational licensing in the department;

b. the division of banking, securities, and corporations in the department shall continue to administer functions under the Alaska BIDCO Act (AS 10.13) and duties related to required statements of financial conditions of business entities required under state law;

c. beginning on the effective date of this Order, documents related to the formation, licensing, or registration of business entities shall be issued in the name of the department;

d. the names of the division of banking, securities, and corporations and the division of occupational licensing in the department remain unchanged by this Order.

4. **CENTRALIZED DATABASE.** The division of occupational licensing in the department shall create a centralized database for registration of names of corporations and other business entities, and for names used by business entities to obtain business and occupational licensing by the department. The centralized database shall also provide a systematic means of verifying whether business entities have secured the required business license from the department and have paid required fees of the department for these activities.

5. **INTERNET ACCESS.** Consistent with law, the department shall proceed with its plan to facilitate business formation, registration, licensing, and trademarking through use of the Internet, to encourage business development in this state.

6. **STATE REGULATION CHANGES.** Consistent with law, the department shall promptly facilitate changes to state regulations necessary to implement this Order.

This Order takes effect immediately.

DATED at Juneau, Alaska, this 17th day of September, 2004.

/s/Frank H. Murkowski
Governor

SB

67

SENATE COMMITTEE REPORT
First Committee of Referral

DATE: 1/21/05

FURTHER: Judiciary

Date of 5-Day Notice: _____
(in accordance with Uniform Rule 23)

DATE TURNED IN TO OFFICE: _____

Labor and Commerce Committee considered SENATE BILL NO. 67

SB 67 CLAIMS AGAINST HEALTH CARE PROVIDERS

"An Act relating to claims for personal injury or wrongful death against health care providers; and providing for an effective date."

and recommends:

[ ] be **replaced** with _____ **CS** _____ (_____)

[ ] adopt **previous** _____ **CS** _____ (_____)

[ ] attached amendment(s)

[ ] adopt Letter of Intent by _____ Committee

[ ] further referral to _____ Committee

Senate Bill:
[ ] Same Title
[ ] New Title

House Bill:
[ ] Same Title
[ ] Technical Title Change
[ ] New Title w/ SCR #____

NEW FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

PREVIOUS FISCAL NOTE(S):

Department	Date	Fiscal	Indet.	Zero	FN#

[ ] **APPROPRIATION - no fiscal note**

SIGNATURES AND RECOMMENDATIONS:	DO PASS	DO NOT PASS	NO REC	AMEND
		✓		
	✓			
	✓			
CHAIR:	✓			

COMMENTS ON SB 67

Mr. Chairman, members of the Committee, I am Rod Betit, President of the Alaska State Hospital & Nursing Home Association. ASHNHA's membership includes all but one of the 31 hospitals and nursing homes throughout the State.

I appreciate the opportunity to offer comments today on Senate Bill 67 on behalf of my members. First, let me say that ASHNHA strongly supports this bill and urges your favorable consideration of it.

As has been stated, this measure is about ACCESS to physician care, now and in the future.

We are advocating a change in only one area of our medical liability laws, that part dealing with non-economic damages.

Why? We believe this component continues to hurt Alaska's efforts to recruit and retain an adequate number of physicians in each specialty area.

We believe modifying this provision will improve the situation yet will still provide injured patients with fair compensation.

As a reminder, we are not advocating a change in other key components of Alaska's medical liability laws which include:

- Provisions for economic damages and punitive damages
- Periodic payment of damages awarded
- Collateral benefits (offsetting against damages collected from other parties)
- Apportionment of damages (assigning percentage of fault among parties)

These components are working fine in our opinion.

Nor are we advocating the provision in President Bush's proposal that would limit attorney fees. We do not see a need to go that far to correct the concerns we have.

So, what are our concerns about access?

First, we are concerned that our collective goal of providing timely medical care in the most cost-effective setting is being undermined by shortages in certain physician specialties, and that this will worsen in the years ahead.

Outpatient Setting

In the outpatient primary care setting, serious shortages already exist in the following physician specialty areas (documented in a survey focusing on Providence statewide service area):

- Family/General Practice
- Internal Medicine
- Pediatrics

As patients call to make an appointment with a physician for their first visit, some are already being asked to go through an "application process". Some are accepted, some are not as physician practices become overwhelmed.

This leads to patients self-referring to ERs or having to wait weeks for an appointment IF they can get one.

As we all know, use of ERs and delaying diagnosis/treatment of potentially serious illness has an adverse impact on everyone's health care costs, not to mention the frustration and anxiety it causes for the patient.

Inpatient Setting

In the inpatient hospital setting, unless some of our specialty gaps are closed, we could see increasing delays in scheduling needed surgery and treatment for non-emergency procedures.

At the present time the following physician specialty areas are well below needed levels:

- Psychiatry
- Allergy & immunology
- Neurosurgery
- Rheumatology
- Gastroenterology

In addition the primary care physician shortage mentioned above makes it difficult to refer patients back into the community for follow-up care after leaving the hospital.

On the positive side, with exceptions in some communities, we seem to be doing ok in the following specialty areas:

- ER
- Pulmonary diseases
- General surgery
- Hematology/Oncology
- OB/Gyn
- Cardiology
- Urology

However, there are some communities where these specialty areas are inadequate or non-existent altogether.

In rural communities the loss of one or two doctors puts stress on the entire system, outpatient and inpatient settings both.

For example, in Soldotna, it has been reported to me that some family practice physicians have stopped providing OB care because of prohibitively high professional liability insurance costs. This makes the physician shortage even more acute as these "limited practice" situations are not reflected in the numbers mentioned above.

When physicians consider where to establish or keep a practice there are a few critical factors they look at:

- **Salary**:
  Physicians can only generate a certain amount of revenue for the # of patients seen. Insurance, both public and private, set the reimbursement. Alaska generally does well here.
- **Business Climate:**
  Alaska does well here with the low penetration of managed care insurance arrangements.
- **Uninsured Load:**
  With one of the highest uninsured rates in the country, Alaska does not score well here but it is manageable if other factors make up for it.
- **Lifestyle:**
  Alaska gets exceptionally high marks here.
- **Medical Liability Cost:**
  You glean this information from your colleagues in other states. If their experience is that it is expensive now, and getting more expensive every year, and they have to limit their practice or leave the industry, you don't get high marks.

The biggest unknown factor in establishing or continuing an Alaska practice is the medical liability cost. It is a large enough factor it can offset the other positives about the State.

We believe from our experiences and discussions with physicians that this is a real problem that we must address if we hope to improve our physician supply in critical specialty categories.

For these reasons ASHNHA encourages your support of SB 67.

We believe the narrow nature of this legislation addressing just the non-economic damages cap will go a long way to demonstrate that the State is committed to injured patients receiving fair compensation, but that we are also concerned about insuring a viable environment in which all Alaskans will be able to have timely ACCESS to a physician in the years ahead.

Mr. Chairman, that concludes my testimony and I would be happy to respond to questions from the Committee.

Additional Documents
SB 67

Malpractice Insurance Comparables

Arizona Compared With Other States For: General Surgeons, Internists, and OB/Gyn

	State	Internist Rates 2004		State	General Surgeon Rates 2004		State	OB/Gyn Rates 2004
1	FL	$69,310	1	FL	$277,241	1	FL	$277,241
2	MI	$63,898	2	MI	$193,819	2	IL	$230,428
3	IL	$58,514	3	IL	$183,560	3	PA	$172,178
4	OH	$41,998	4	PA	$135,406	4	TX	$165,054
5	PA	$36,873	5	MO	$132,314	5	MI	$164,934
6	TX	$36,018	6	OH	$130,813	6	OH	$152,109
7	CT	$28,917	7	TX	$128,239	7	CT	$148,164
8	WV	$27,499	8	NY	$108,466	8	MO	$147,406
9	MO	$27,088	9	NV	$85,928	9	NY	$146,615
10	NY	$25,091	10	NJ	$83,549	10	NV	$133,904
11	NJ	$23,818	11	DE	$83,079	11	WV	$128,331
12	NV	$23,734	12	WV	$79,975	12	NJ	$128,304
13	DE	$21,302	13	WY	$69,250	13	MD	$127,201
14	CA	$20,283	14	CA	$68,007	14	NC	$111,149
15	WY	$20,029	15	MD	$67,022	15	MA	$105,006
16	MD	$19,911	16	CT	$65,198	16	VA	$103,651
17	NC	$19,146	17	NC	$65,147	17	DE	$93,091
18	GA	$17,547	18	WA	$59,413	18	RI	$92,134
19	MS	$17,046	19	UT	$57,796	19	CA	$89,953
20	LA	$16,548	20	MS	$57,710	20	WY	$87,527
21	**AZ**	**$16,502**	21	GA	$56,958	21	KY	$85,658
22	WA	$15,869	22	NM	$56,639	22	LA	$82,259
23	VA	$15,158	23	KY	$56,538	23	GA	$82,210
24	MA	$12,908	24	VA	$55,223	24	MS	$82,108
25	AK	$12,812	25	LA	$52,944	25	UT	$81,628
26	CO	$12,711	**26**	**AZ**	**$51,188**	26	CO	$80,572
27	NM	$12,586	27	MT	$48,249	27	MT	$80,199
28	KY	$12,533	28	CO	$47,863	28	WA	$71,994
29	RI	$11,812	29	RI	$44,886	29	NM	$70,808
30	OR	$11,353	30	AK	$41,289	30	OR	$70,386
31	MT	$11,306	31	SC	$40,950	31	AK	$70,348
32	OK	$11,050	32	OR	$40,756	**32**	**AZ**	**$67,027**
33	NH	$10,935	33	NH	$40,110	33	NH	$61,773
34	UT	$10,801	34	TN	$39,570	34	HI	$61,684
35	ND	$10,502	35	MA	$39,474	35	TN	$59,571
36	HI	$10,284	36	IN	$37,152	36	IN	$58,020
37	KS	$10,276	37	HI	$37,012	37	KS	$51,835
38	ID	$9,906	38	OK	$35,455	38	VT	$51,585
39	IN	$9,776	39	KS	$34,248	39	ID	$48,251
40	WI	$9,570	40	ID	$34,192	40	SC	$47,739
41	IA	$9,350	41	ND	$30,917	41	IA	$47,174
42	SC	$9,094	42	IA	$30,636	42	AL	$41,737
43	AR	$8,897	43	AL	$30,515	43	AR	$41,103
44	TN	$8,710	44	AR	$29,026	44	OK	$40,392
45	MN	$8,006	45	MN	$27,749	45	ME	$37,663
46	AL	$7,484	46	SD	$23,382	46	WI	$36,742
47	SD	$7,320	47	ME	$22,830	47	ND	$36,179
48	VT	$7,237	48	WI	$21,727	48	MN	$34,158
49	ME	$7,206	49	VT	$21,347	49	SD	$28,578
50	NE	$3,478	50	NE	$14,819	50	NE	$22,682

Notes:

1. Rates are based on the *Medical Liability Monitor*, October 2004, Vol. 29, NO. 10.

2. Ranking is by state, based on the highest rate reported in each state for each speciality.

3. Arizona's rates are MICA's rates.

Division of Insurance

For SB 67

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

February 8, 2005

Honorable Con Bunde and
Senate Labor and Commerce Committee
Alaska State Senate
State Capitol, Room 506
Juneau, AK 99801

Re: SB 67 – Medical Liability Reform

Dear Senate Bunde and Senate Labor and Commerce Committee Members:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily interested in ensuring that Alaska's citizens have access to high quality health care. ASMA strongly supports SB 67, which provides for meaningful medical liability reform and urges you to support it as well.

SB 67 establishes a $250,000 maximum for the unquantifiable damages known as non-economic damages. Non-economic damages are also known as "pain and suffering" damages. SB 67 does not limit the quantifiable economic damages such as lost wages, and post and future medical care costs. (SB 67 defines economic damages, which are not currently defined in Alaska statutes.)

ASMA asserts that enactment of SB 67 will provide for equitable and more predictable settlements in medical injury cases. The result will be a more stable professional liability insurance marketplace and, most importantly, will help us recruit physicians to help fill our chronic shortage of physicians.

The American Academy of Actuaries[1] has stated that medical liability reform establishing a $250,000 limit is imperative in stabilizing the physician professional liability insurance marketplace. A recent study[2] of medical students found the legal environment and the availability of affordable liability insurance plays a major part in a graduate's decision as to where to set up practice.

Access to medical services is limited in much of the state. Alaska has one of the smallest numbers of physicians per capita in the country. An American Medical News story pertaining to the special Medical payment reform for Alaska noted our precarious situation: "Alaska has long ranked among the worst states in terms of physician supply. In 2002, the state had fewer than 1,350 doctors in private practice and another few hundred in the military or other government posts…only six states had a lower doctor to patient ratio."[3] This data indicates that to reach the national average, Alaska would need about 500 more actively practicing physicians. This determination is future substantiated in Molly Southworth, MD, July 2004 Masters of Public Health Thesis, titled "Alaska's Physician Workforce: An Overview, a Summary of Training Background, and the Impact of the WWAMI Program".[4] Exacerbating the problem is the aged physician workforce. ASMA's database shows nearly 50% of our physician workforce over age 50. Dr. Southworth's Thesis[5] as well as Leslie Gallant of the State Medical Board[6] further validates that fact. The Providence Alaska Medical Center confirmed in its 2002 study that physicians in its service area were getting older and highlighted immediate acute shortages in psychiatrists, surgeons, and general internists, among

others.⑦ In 2002, the total shortage identified in primarily the Anchorage bowl area totaled about 200. The Providence study was updated for 2005 and projected the physician workforce needs to 2009.⑧ The Shortage in 2005 is still at around 200, with a projected shortage in 2009 of 261.

The recruitment challenge is the main reason medical liability reform is so important to Alaska. Unfortunately, the state does not have the capacity to "grow" its own physicians. Alaska has no medical school, and of the small number of students graduating annually from the WWAMI program, some do not return to practice. Likewise, the state's lone residency training program is small. Alaska is, and will continue to be a net imported of doctors. As such, we have to compete with other states facing physician shortages, a competition that is influenced significantly by the state's medical-legal practice environment.

ASMA asserts that SB 67 is a critical element in helping us improve our practice environment so as to help in physician recruitment. Well trained physicians in sufficient numbers are ASMA's greatest concern so that all Alaskans have access to high quality care when it is needed. Alaskans need and deserve local health care without having to be flown out of state for treatment.

ASMA urges you to support SB 67.

Sincerely,

Paul Worrell, MD

By: Paul Worrell, MD President
For: The Alaska State Medical Association

cc: Senator Ralph Seekins
Senator Ben Stevens
Senator Johnny Ellis
Senator Bettye Davis

Footnotes:

① Issue Brief, American Academy of Actuaries, "Medical Malpractice Tort Reform: Lessons from the States", Fall, 1996, p. 4.
② "AMA Survey: Medical Students' Opinions of the Current Medical Liability Environment: American Medical Association Division of Market Research and Analysis, November 2003.
③ "Medicare Law Aims to Bring Alaska Physicians in from the Cold." AM News, 1/19/2004.
④ "Alaska's Physician Workforce: An Overview, A Summary of Training Backgrounds, and the Impact of the WWAMI Program", Molly B. Southworth, MD, 7/2004, Masters of Public Health Thesis, pp 26-33.
⑤ See Southworth ④, pp 12-14.
⑥ "Shingle Shortage?", Anchorage Daily News, Ann Potempa, 9/3/2002
⑦ "Physician Workforce Analysis", Providence Health System Alaska, November 2002, pp 17-18.
⑧ "PAMC Physician Supply and Physician Need Estimate: Summary", Providence Alaska Medical Center, February 2005.

For SB67

AARP Alaska

February 8, 2005

The Honorable Con Bunde Chair
Senate Labor and Commerce Committee
Alaska State Capitol, Room 506
Juneau, Alaska 99801-1182

RE: SB 67 (Seekins)—Oppose Unless Amended

Dear Chair Bunde:

On behalf of the AARP members in Alaska, we ask that you and your colleagues on the Senate Labor and Commerce Committee oppose SB 67, authored by Vice-Chair Seekins, unless it is amended.

The issue of medical malpractice is often perceived as a battle between trial lawyers and insurance companies and physicians. We think it is also important to consider the victim of malpractice as well as **the ultimate goal of medical error reduction.**

AARP believes that state legislatures should not place limits on the amount of punitive damages or on joint and several liability, or unreasonable limits on damage awards for pain and suffering. We believe that a cap of $250,000 is, on its face, unreasonable.

For a cap to be reasonable, it would:

- Start at a level based on current conditions, not the arbitrary $250,000 figure chosen in California some 20 years ago,
- Provide flexibility for different types of cases,
- Include exceptions for egregious cases,
- Be indexed for inflation, and
- Be tied to other reforms, including mandatory error reporting and prompt payment requirements.

We oppose caps on punitive damages because these awards are relatively rare and generally imposed only in the most egregious cases, and thus are not a significant factor in malpractice premium problems.

3601 C Street, Suite 1420 | Anchorage, AK 99503 | toll-free 866-227-7447 | 907-341-2270 fax | toll-free 877-434-7598 TTY
Marie F. Smith, President | William D. Novelli, Chief Executive Officer | www.aarp.org/ak

It's not just physicians who need malpractice reform. Consumers injured by medical errors are also served badly by the tort system, and real reform requires going beyond the doctor vs. lawyer debate.

The tort system does a poor job of compensating people injured by medical errors. It is slow, expensive, and most injured people get nothing at all. The tort system also encourages providers to cover up mistakes in order to avoid lawsuits, rather than report errors in order to learn how to prevent them in the future.

We need to move beyond the debate over caps. Proposals to set unreasonable limits on pain and suffering awards do not help injured people get compensation or reduce errors. In fact, such caps can make it even harder for people who are injured to get fair compensation. AARP believes they are also unfair to older people with limited income potential who thus get little in economic damages.

Real reform should lead to fair compensation and error reduction. The Institute of Medicine (IOM) has proposed demonstration projects to test reform designed to fix what is broken for consumers. IOM has proposed testing non-judicial, no-fault alternatives to the tort system for medical errors (but not for other types of harm to patients, such as nursing home negligence). These alternatives could foster fair compensation and error reduction—what we believe should be the goals of consumer-oriented reform.

Under the IOM proposal, people with legitimate cases of medical injury could be identified and compensated appropriately. Payments would be based on "avoidability" of errors rather than "negligence." Amounts would be preset in schedules for specific categories of errors, which would provide reasonable limits that may help stabilize malpractice premiums. Health providers would have to report errors and make payments promptly, which would help injured people get fair compensation.

Errors could be reduced so fewer people would be injured. By requiring providers to report errors, the IOM claims that experts would be able to analyze system-wide errors and find ways to prevent them. The result would be a system in which patient safety is continually improved. With fewer errors, the cost of compensating injured people could decline.

We assume that reducing medical errors is in the best interest of all Alaskans and is the real intent of Senator Seekins in SB 67. We encourage you and your colleagues on the Senate Judiciary Committee to amend SB 67 to reflect the recommendations of the Institute of Medicine. Fair compensation and error reduction—AARP thinks we can all live with that.

Should you have any questions about our position, please feel free to contact me (586-3637), or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Ralph Seekins
Senator Ben Stevens
Senator Johnny Ellis
Senator Bettye Davis

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 67
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Commerce
Title: Claims Against Health Care Providers
RDU: Occupational Licensing (117)
Component: Occupational Licensing
Sponsor: Seekins
Requester: Senate Labor & Commerce
Component No.: 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (1156)	0.0	0.0	0.0	0.0	0.0	0.0

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
1156 - Receipt Supported Services						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

Estimate of any current year (FY2005) cost: 0 0

Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This legislation has no impact on the operations of the division.

Prepared by: Jennifer Strickler, Administrative Manager
Phone: (907) 465-2144
Division: Occupational Licensing
Date/Time: 2/4/05 5 59 PM
Approved by: Edgar Blatchford
Date: 2/4/2005
Agency: Commerce, Community, and Economic Development

(Revised 9/23/2004 OMB)

THE ALASKA ACTION TRUST
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POSITION PAPER ON SENATE BILL 67
Alaska Action Trust

INTRODUCTION

In Alaska, to suggest that there is a medical malpractice crisis is at best disingenuous and at worse fraudulent. In short, there is no empirical evidence to support the proposition of a relationship between medical malpractice premiums, medical malpractice litigation and availability of health care providers.

If this proposed legislation passes, you will be responsible for eliminating the ability of stay at home moms and dads, retired or elderly citizens, children, and those with subsistence lifestyles or limited incomes to bring claims against negligent or even reckless doctors or other health care providers. This will be true even when they are blinded, maimed, suffer serious neurological injuries, rendered sexually dysfunctional or even killed by medical malpractice. What makes this proposed legislation even more egregious is that the entire premise for its utility is based upon anecdotal information, unsupported by credible empirical evidence and indeed is contrary to conclusions reached in existing and reliable studies.[1] Even more appalling, there is no corresponding assurance from those most benefited (the insurance industry) that the legislation will have *any* effect whatsoever on medical malpractice rates.

THE HISTORY OF TORT REFORM IN ALASKA

While the following discussion will illustrate the points referenced above, a brief chronological history of similar tort reform efforts in the State of Alaska demonstrates that capping or limiting damages will have absolutely no effect on medical malpractice insurance rates or the availability of medical malpractice insurance to doctors in Alaska or the availability of health care in Alaska.

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[1] Studies repeatedly relied upon by the insurance industry and health care providers pushing similar legislation have been widely discredited. The Milliman report, for instance, relies on data from the National Practitioner Data Bank (NPDP) that has been slammed by the Government Accounting Office (GAO). (*See, e.g.*, GAO: "National Practitioner Data Bank: Major Improvements are Needed to Enhance Data Bank's Reliability," Nov. 2000; Mary Jane Fisher, "GAO Report Slams National Practitioner Data Bank," *National Underwriter*, Jan. 1, 2001). It also fails to adjust any of its figures for medical inflation to offset its conclusion that medical malpractice losses have risen 32% over the last decade in states without caps. When adjusted for 51% in medical inflation for the same time period, paid losses are actually *falling*.

Dating back to 1976 with the passage of A.S. 09.55.548, medical malpractice insurers and health care providers have enjoyed a unique benefit unavailable to other insurers or private citizens. A.S. 09.55.548(b) in effect immunizes these entities and individuals from payment for all past medical expenses incurred as a result of physician and/or health care malpractice paid by private health care plans.

This has resulted in a significant windfall to medical malpractice carriers (and uninsured health care providers) since a private health care plan has no subrogation rights under the statute. The only exception to this windfall is when the collateral source of payment is governmental or quasi governmental such as under Medicare, Medicaid or federal employees who are insured under the federal health care plan. In many cases, this results in savings totaling hundreds of thousands of dollars which are absorbed, unfairly, by other health care plans and ultimately by the citizens of this state through higher health care premiums.

In 1978, again at the urging of medical malpractice insurance carriers and health care providers, the Legislature passed A.S. 09.55.536 requiring the appointment of expert advisory panels in all medical malpractice actions. These panels were appointed by the court and reviewed claims brought by injured Alaskans to determine whether or not malpractice had occurred and, if so, whether the malpractice had caused the patient's injuries. The purported basis for this legislation (as argued by its proponents) was to eliminate or at least minimize frivolous malpractice claims. While the efficacy of the expert advisory panel was always questionable, it has been all but abandoned by health care providers themselves and is no longer requested (it is waived in virtually all cases).

In 1986, the Legislature enacted tort reform legislation placing damage caps on non-economic damage. That legislation capped non-economic damages for injuries that did not result in severe permanent physical impairment or severe disfigurement to $500,000. There was no cap, however, on those injuries that did result in severe permanent impairment or severe disfigurement.

In 1997, sweeping tort law revision was enacted by the Legislature. The previous cap on non-economic damages in cases involving physical injury was reduced to $400,000 (or the injured person's life expectancy multiplied by $8,000) A definitive cap was placed on cases involving severe permanent physical impairment and severe disfigurement of $1,000,000 or the injured persons life expectancy in years multiplied by $25,000. In other words, to exceed the $1,000,000 limitation, a person's life expectancy would have to exceed 40 years.[2]

While the 1997 changes benefited all insurance carriers in the state of Alaska, health

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[2] We mistakenly advised the Committee last week that the cap on non-economic damages was the lesser of $1,000,000 or a multiplier of a person's life expectancy. After reviewing the statute, we realized our mistake. Our oversight underscores the rarity of any claim for non-economic damages exceeding that threshold.

care providers were given additional protection in the form of limiting expert witnesses who could testify on behalf of an injured Alaskan in medical malpractice actions.

A.S. 09.20.185 was enacted requiring that only board certified physicians having expertise and training directly related to the particular field or matter at issue would be allowed to testify regarding standard of care. This requirement is now necessary even though the offending doctor is not board certified in any practice group or specialty. Needless to say, this has made it even more difficult to obtain expert witnesses to testify against offending doctors, particularly since the same doctors belong to national organizations and often know each other personally.

In the face of these sweeping reforms, the insurance industry has repeatedly argued that tort reform benefits policyholders and the public at large. To date, there have been *no* reductions to my knowledge in any insurance rates charged to individual Alaskans. The current legislation that will benefit only health care providers will result in the same outcome. There will be no reduction in health care costs and no reduction in medical malpractice premiums charged in the state of Alaska. As discussed below, this has been repeatedly demonstrated throughout the United States.

THE HISTORY OF MALPRACTICE PREMIUMS IN ALASKA

To best illustrate this point, it is helpful to review the medical malpractice premiums charged in this state dating back to 1993 and compare those to California, the state much touted by the insurance industry because of its previously imposed caps on non-economic damages through the Medical Injury Compensation Reform Act (MICRA). Although the only published premium information readily available deals with the specialties of Internal medicine, General Surgery and OB/GYN, these seem to be the specialties of most concern at least by those physicians and health care providers who testified before the House Judiciary last week.[3]

A cursory review of the premiums charged illustrates the utter lack of credibility of the positions taken by this legislation's proponents. An important thing to remember when reviewing the premiums discussed below is that these are the amounts *charged* by the malpractice carriers. Both NORCAL and MIEC (the current and historical dominant carriers in the Alaska market) give credits back to their insureds. These credits are *not* reported in the data available but it is highly likely that these credits would further substantially reduce the published premiums paid by individual health care providers.[4]

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[3] Medical Liability Monitor [MLM] of Chicago publishes annual rate surveys from premium submissions provided by medical malpractice carriers or obtained directly from state insurance departments throughout the United States.

[4] MLM notes in all of its annual surveys that such credits, discounts and other factors can greatly diminish and sometimes completely offset rate increases. None of the surveys reflect this data, however.

In 1993, NORCAL's premium rates were $12,102 for Internal Medicine doctors, $37,750 for General Surgeons, and $64,518 for OB/GYN's. MIEC's premium rates for the same specialties were $5,487, $19,752, and $32,916 respectively. From 1994 through 1996, NORCAL's rates remained relatively stable. In 1994, MIEC raised its premiums for General Surgeons and OB/GYN's to $38,228 and $63,712 respectively. In 1995, MIEC reduced those rates by about 10 percent.[5]

Between 1997 and 1999, premium rates actually decreased significantly. NORCAL's rates dropped to $8,770 for Internal Medicine doctors, $28,587 for General Surgeons, and $48,706 for OB/GYN's. MIEC reduced its rates to $8,172, $29,420, and $49,032 respectively.[6]

There is no dispute that during this time frame and extending into 2001, most carriers in most states were reducing malpractice premiums because of intense competition in the industry. This competition was reflected in the state of Alaska by the joining of at least two other malpractice carriers to the competitive market.[7] The introduction of new carriers into the competitive market was a national phenomenon. Fierce competition continued to drive down rates for medical professional liability insurance in 1997.[8] In 1999, medical malpractice carriers had been battered from several years of brutal competition, with price cutting the name of the game, even when it meant selling *below* the break-even point.[9]

Back then, leaders in the industry were optimistic that the market would "harden" over the next three years.[10] Then vice president of Florida Physicians Insurance Company, Melodee Dixon, stated, "It will take that amount of time [three years] for claims on policies written at today's grossly inadequate rates to shake out."

Everyone in the industry during this time frame recognized that the amount of

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5 MLM annual surveys for 1993-1995.

6 MLM annual surveys for 1997-1999.

7 Although other carriers may have been in the Alaska market during this time frame, the only entities reporting premiums to MLM appear to be NORCAL, MIEC and joined in 1996 by Physicians Ins. Ex. of Washington and Doctors Co. in 1997. Northwest Physicians Mutual began reporting in 1999. It is unknown when CNA began writing coverage in Alaska.

8 MLM annual survey comments, 1997.

9 "Medical professional liability writers express a very pragmatic, but somewhat optimistic outlook about their market niche. Battered from several years of brutal competition, with price-cutting the name of the game, even when it means selling below the break-even point, these insurers nevertheless think that a market shake-out will come." MLM annual survey, 1999.

10 Market "hardening" is discussed, *infra*.

competition in the industry was causing drastic price cutting and exposing numerous carriers to significant financial risks in the future. These risks were self-inflicted and the resulting losses from malpractice claims were anticipated and predicted by competent actuaries.

The trend of lower malpractice premiums continued through 2000 in the state of Alaska. In 2001, as competition in Alaska and the national market waned, the predicted market "hardening" began to take form. Those carriers that had engaged in risky if not reckless underwriting began to pull out of markets in this state and across the United States. Notwithstanding, the malpractice premium rates in Alaska remained unchanged at MIEC through 2002 and were increased only slightly by NORCAL. In 2001, NORCAL raised its rates to $9,580 for Internal Medicine doctors, $30,872 for General Surgeons, and $52,600 for OB/GYN's.[11]

In 2003, with the market firmly "hardened," the rates from both carriers increased. NORCAL raised its rates for Internal Medicine doctors to $11,209, for General Surgeons to $36,122 and for OB/GYN's to $61,545. MIEC's premium rates were $7,432, $26,748, and $44,580 respectively. Notwithstanding, the premiums charged for 2003 were *less* than those charged by NORCAL for the same practice specialties in 1993, 1994, 1995, 1996 and only slightly higher than those charged in 1997 and 1998. The premium rates charged by MIEC in 2003 were less than those charged by the carrier in 1994, 1995, 1996, 1997, 1998, 1999, and only slightly higher than the premiums charged in 2001 and 2002.[12]

The significance of this rate comparison is even greater when comparing the discounted value of 2003 dollars with the previous years of lower premium rates. In short, these figures reflect an actual *reduction* in malpractice premiums over this time period when viewed in that light without considering the premium credits refunded to health care providers over this same time period. Moreover, when comparing these premiums to the inflation rate of health care costs (and resulting income to physicians), it is clear that these rates have not resulted in *any* increase to the cost of malpractice insurance premiums to health care providers in Alaska through 2003.

THE CALIFORNIA EXPERIENCE

Since California's non-economic damage cap legislation seems to be the model being touted by the proponents of this legislation, it is helpful to review the medical malpractice premiums charged in that state.

Between 1991 and 1997 In California, the medical malpractice premiums for internal medicine doctors, general surgeons and OB/GYNs remained relatively constant between 1991 and 1997. The premium rates charged by NORCAL over that time

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11 MLM annual survey 2000-2001.

12 MLM annual survey 2003.

period for Internal Medicine doctors ranged from $5,692 to $9,472, for General Surgeons, $18,916 to $29,440, and for OB/GYN's, from $31 624 to $49,208. MIEC's premium rates were $5,776, $20,792, and between $34,648 and $39,268 respectively.[13]

Of particular note, and as recognized by numerous commentators, the reason for the relative consistency over this time period had little or nothing to do with medical malpractice non-economic damage caps.

In 1975, California enacted the Medical Injury Compensation Reform Act (MICRA) that placed a cap of $250,000 on non-economic damages in medical malpractice actions. MICRA was touted by the insurance industry and health care practitioners as the solution to the "malpractice crisis" and the solution to increasing malpractice insurance rates. By 1988, however, medical malpractice premiums were 190% higher than 1976 levels (40% when adjusted for inflation to 2001 levels).[14]

In 1988 California voters passed Proposition 103, an insurance reform proposal. This proposition rolled back insurance rates 20% and froze rates for one year. It mandated billions of dollars worth of refunds to policyholders and created a system that required approval of insurance rates, allowing the insurance Commissioner to deny rate proposals that were too high or too low to be actuarially justified. It is following this proposition through 1996 that malpractice insurance rates actually stabilized.[15]

Beginning in 1997, insurance rates in California *again* began to increase substantially. In 1997, NORCAL's premium rates for Internal Medicine doctors ranged up to $9,472, for General Surgeons, up to $29,440 and for OB/GYN's, up to $49,208. The rates continued to increase slightly between 1999 and 2001. Since that time, through 2003, the rates have increased to ranges up to $25,178, $58,830, and $77,814 respectively. During this same time period, MIEC's premium rates have increased from their 1996 -- 1998 rates to a range up to $9,305, $27,682, and $50,340 respectively. Accordingly, even with MICRA reform, malpractice rates have steadily *risen* in California and are comparable to or substantially greater than malpractice premium rates charged in this state by the same companies notwithstanding the lack of additional caps on non-economic damages.[16]

THE INSURANCE INDUSTRY ADMITS THAT CAPS WILL NEITHER REDUCE PREMIUMS NOR ARE CAPS RELATED IN ANY WAY TO THE AVAILABILITY OF HEALTH CARE

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13 MLM annual surveys, 1991-1997.

14 *How Insurance Reform Lowered Doctors Medical Malpractice Rates in California*, The Foundation for Taxpayer and Consumer Rights, February 10, 2003, excerpted from N.C. trial lawyers expose on malpractice rates in N.C.

15 *Id.*

16 MLM annual surveys, 1996-2003.

Misinformation regarding the efficacy of caps on non-economic damages and purported decreases in medical malpractice premiums has been disseminated by health care providers and malpractice insurers in other states as well.

In Florida, after pushing through a sweeping medical malpractice bill in August with a promise to reduce ever-increasing insurance premiums for Florida's physicians, malpractice insurance carriers followed up the bill's passage with a request to increase premiums by as much as 45 percent.[17]

In 2003, Oklahoma passed a tort reform bill that included a severe cap on compensation available to certain medical malpractice victims. Following passage of that bill, the insurance company owned by the state medical association requested an astounding 83 percent rate hike which was subsequently approved on the condition that it be phased-in over three years.[18]

In January 2003, Ohio lawmakers enacted a cap on compensation for patients injured by medical malpractice. Almost immediately, all five major malpractice insurance companies in Ohio announced that they would not reduce their rates. One insurance executive predicted his company would seek a 20 percent rate increase.[19]

This should come as no surprise to those familiar with the insurance industry and particularly with malpractice carriers.

Bob White, president of First Professional Insurance Co., the largest medical malpractice insurer in Florida stated that "no responsible insurer can cut its rates after a [medical malpractice tort reform] bill passes."[20] Cliff Webster representing the Washington State Medical Association and Chairman of the Washington Liability Reform Coalition told the Washington State Legislature, House Judiciary Committee in 2003 that "I don't think we would argue that the premiums are likely to go down."[21]

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17 *See, e.g.*, Julie Kay, "Medical Malpractice; Despite Legislation that Promised to Rein in Physicians Insurance Premiums, Three Firms File For Big Rate Increases," *Palm Beach Daily Business Review*, Nov.20, 2003.

18 *BestWire*, Dec. 2, 2003.

19 Laura Bischoff, "Taft Signs Malpractice Reform Bill; Cap on Awards for Pain and Suffering," *Dayton Daily News*, Jan. 11, 2003; Andrew Welsh-Huggins, "Doctors Pushing for Short-Term Relief From Malpractice Rates," *Associated Press*, Jan. 10, 2003; "Despite New Law, Insurance Companies Won't Lower Rates Right Away," *Associated Press*, Jan. 9, 2003.

20 *Palm Beach Post*, Jan. 29, 2003.

21 Testimonial excerpt from testimony before the Washington State Legislature, House Judiciary, Feb. 21, 2003.

Sherman Joyce, President of the American Tort Reform Association candidly acknowledged, "We wouldn't tell you or anyone that the reason to pass tort reform would be to reduce insurance rates."[22] James Robertson, Assistant Vice President and Associate Actuary for SCPIE Indemnity Company (California's second largest medical malpractice insurer) stated "while MICRA was the Legislature's attempt at remedying the medical malpractice crisis in California in 1975, it did not substantially reduce the relative risk of medical malpractice insurance in California." He made that statement in a written response to a question from an administrative law judge overseeing the case in which his company had requested another 15.6% rate hike.

In short, virtually every reliable empirical source underscores the certainty that limiting an injured persons access to the court system for damages has little or nothing to do with insurance premiums for the cost of health care delivery.

In January 2004, the Congressional Budget Office (CBO) concluded that legislation to cap damages in medical malpractice lawsuits would do little to hold down health care spending or eliminate the practice of defensive medicine. Moreover, the report found that medical malpractice insurance premiums have increased in part because of reduced income from insurer investments and short-term factors in the insurance market. The report found that although malpractice insurance premiums are somewhat lower in states with caps on damages, even a large savings in premiums would have a small impact on total health care spending because malpractice insurance costs account for less than two percent of health care spending. The CBO concluded that caps on damages in malpractice suits would not likely end the practice of defensive medicine. That is because physicians who practice defensive medicine may do so less because they fear liability than to generate more income. Equally compelling, the GAO concluded that many reported shortages of health care services [based on these factors] could not be substantiated or did not widely affect access to health care.[23]

In a sweeping and thorough investigation for AIR under the direction of Mr. Robert Hunter (former Federal Insurance Administrator and Texas Insurance Commissioner) it was determined that insurers make most of their profits from investment income. During years of high interest rates or excellent returns in the market, insurance

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22 "Study Finds No Link Between Tort Reforms and Insurance Rates," *Liability Week*, July 19, 1999.

23 *Congress Daily*, Jan. 13, 2004. The same argument of "fleeing" doctors and fear of inability to attract new ones has been completely debunked in Washington. Doctors for Medical Liability Reform claimed that 500 doctors had left the state between 1998 and 2004. They failed to mention, and did not research, however, how many doctors had moved to Washington over the same time frame. According to the 2003 GAO report, there were more doctors per capita in 2001 than in 1998. Moreover, despite arguments to the contrary, there was no indication that health care delivery was being curtailed or eliminated. Carol Ostrom, "Contrary to Ads, Doctors Replaced, Clinics Still Open," *Seattle Times*, Feb. 23, 2004.

companies engaged in fierce competition for premium dollars to invest and maximum returns. They severely under price premiums for policies and insure very poor risks to get premium dollars to invest. This is known as the "soft" insurance market. When the investment climate turns sour, however, the industry responds by sharply increasing premiums and reducing coverage, creating a "hard" insurance market, usually degenerating into a "liability insurance crisis."[24] This is precisely what is proven conclusively by reviewing the comments and premium surveys discussed above.

Moreover, the Hunter report concluded that since the early 1980's, medical malpractice paid claims per doctor has tracked (approximately) medical inflation. In fact, inflation-adjusted payouts for physicians dropped between 2000 and 2002.[25] This data confirms that neither jury verdicts nor any other factor affecting total claims paid by insurance companies that write medical malpractice insurance have had much impact on the system's overall costs over time. Even more compelling, since 1975, the data shows that in terms of constant dollars, per doctor written premiums, the amount of premiums that doctors have paid insurers have gyrated almost precisely with the insurer's economic cycle which is (again) driven by such factors as changing insurance rates, mismanaged business and accounting practices as well as other causes.[26]

MEDICAL MALPRACTICE IN ALASKA – THE REALITY

In summary, what is being touted as a basis for the passage of this legislation is without merit. The following facts underscore why this legislation is bad for Alaskans.

1. Fact: Citizens who are elderly or retired, citizens living a subsistence lifestyle, stay at home parents, and children will be without any legal remedy for even the most egregious instances of medical malpractice. Since they have little or no economic loss, they will not be able to obtain legal counsel to pursue a medical malpractice claim even if they are blinded, crippled, maimed, rendered sexually dysfunctional, or die after a sustained period of suffering. The cost of bringing such claims will easily exceed any potential recovery.

Real-Life Examples:

Linda McDougal -- this is the much-publicized case involving the 46-year-old Navy veteran who underwent a double mastectomy after mistakenly being diagnosed with an aggressive breast cancer. Her pathology results had been mistakenly switched with another woman who in fact had breast cancer. This woman is now horribly scarred for

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24 Americans for Insurance Reform, Medical Malpractice Insurance: Stable Losses/Unstable Rates in Wyoming, Feb. 2004.

25 *Id.*

26 *Id.*

life.

Jennifer -- Jennifer was a beautiful and vibrant 12-year-old Alaskan who was misdiagnosed twice over a three-day period with gingivitis. She was actually suffering from acute leukemia, which was very treatable and survivable but requires a timely diagnosis and urgent medical intervention. This could have been determined with a simple and inexpensive blood test. Unfortunately, given the delay in her diagnosis, she hemorrhaged and died before she could be properly diagnosed. Although this was a clear-cut case of negligence, over $100,000 in out-of-pocket costs were expended before the case settled. Under the proposed legislation, this case could never have been prosecuted and Jennifer, her parents, and three siblings would have been without any remedy at all.

Susan -- Susan was an Alaskan in her early 30's when she was misdiagnosed and refused treatment by several health care providers over a five-day period. Unfortunately, she was suffering from a well-known medical and orthopedic emergency known as cauda equina syndrome. By the time she was finally correctly diagnosed, she had suffered permanent saddle anesthesia (no feeling from her waist to her mid thigh); permanent lower extremity neurological injuries requiring leg braces; and intermittent bowel and bladder dysfunction. Under this legislation, since she could still work at her profession, she would be left with a remedy of $250,000. Despite clear-cut negligence, costs of over $200,000 were expended before settlement was reached.

Traven -- Traven was an adventurous eight-year-old Alaskan boy who sustained lower extremity burns that were entirely survivable and treatable. Unfortunately, due to a series of medical mistakes, he languished for days with an increasingly more severe infection and ultimately lapsed into a coma (with his parents present). He was finally flown to Seattle Children's Hospital where he died. Under this legislation, it would be financially difficult or impossible to bring this claim since his entire family, like Jennifer's above, as well as his estate would be limited to $250,000 in non-economic damages. Although an economic loss to his estate could be claimed, those losses are more difficult to establish for children and are usually so low as to not warrant prosecution of a claim absent non-economic damages.

Mrs. Strong -- Mrs. Strong was a 32-year-old Alaskan mother of two children who was drastically over dosed with a highly caustic chemotherapy drug. The overdose was approximately 8 times what she was supposed to be given and was repeatedly administered over the course of 4 days. She died a horrible death, essentially burning up from the inside out over the course of 6 days. She never had a chance to say goodbye to her children, husband, or her parents. Since she was a mom and essentially out of the work force, she would have had little economic loss and, under this bill, her estate and entire family would be limited to $250,000 in losses.

These are only a few of the many actual cases that we can provide this committee as concrete examples of why this bill works such gross inequities on the innocent people in

our State who are the most vulnerable. If you would like to hear about them, please advise and we will provide additional summaries.

Fact: The passage of this legislation will have no impact on medical malpractice premiums in this state and will have no impact on the ability to attract health care professionals to practice here. Other than anecdotal and unsupported comments to the contrary, there is absolutely no evidence to suggest that health care providers stay away from Alaska because of medical malpractice insurance premiums. Indeed, it is considered one of the top 75 places in the United States to practice medicine.[27] This is based in no small part on the lack of managed-care. Further, according to the State Medical Board, the number of medical board licensees has more than doubled since 1985.[28] As discussed above, the argument that the lack of caps discourages doctors from practicing has been posited and rejected by the CBO and others.

Fact: The Institute of Medicine reported three years ago that as many as 98,000 Americans die annually from medical errors in hospitals. On December 12, 2002, the New England Journal of Medicine reported that 4 out of 10 Americans and 1 out of 3 doctors say that they or their family members have been the victims of a preventable medical error; 10% of doctors say that a family member died as a consequence.[29] How will this legislation address these problems other than to make it financially easier on negligent health care providers and their insurance carriers?

Fact: Repeat offender physicians are responsible for most medical errors. According to a study recently conducted in North Carolina, 3.2% of North Carolina doctors had paid out two or more medical malpractice settlements to patients but were responsible for a total of nearly 42% of all payments reported to the National Practitioner Data Bank.[30] A study conducted by researchers at Vanderbilt University found that doctors with a history of malpractice claims can be expected to have "appreciably worse claims experience" than other doctors in the future.[31] This legislation would protect those health care providers by sharply limiting their exposure for continued malfeasance.

Fact: Medical Malpractice insurance costs are declining as a percentage of physician expenses. A recent USA Today report stated that, on average, doctors

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27 Modern Physician, "The List" www.modernphysician.com.

28 Chart "Total Medical Board Licensees by Fiscal Year, 1985-2003. Division of Occupational Licensing

29 *New England Journal of Medicine*, December 12, 2002.

30 *Medical Misdiagnosis in North Carolina*, Public Citizens Congress Watch, April 2003.

31 "Medical Malpractice Experience of Physicians: Predictability or Haphazard?" *Journal of the American Medical Association*, 1989--cited in Medical Misdiagnosis, *Id.*

currently pay 3.2% of their revenue for medical liability insurance.[32] In 1987, medical malpractice insurance costs were, on average, 12.1% of the physician's total expenses. In the ensuing decade that share was cut in half, falling to less than 7% of total expenses in the late 1990's. Based on the most current statistics available from the American Medical Association, there is a clear and consistent decline in medical malpractice costs as a percentage of a physician's total expenses.[33]

Fact: Medical malpractice cases make up a very small percentages of cases filed in Alaska.

Fact: Most medical malpractice verdicts in Alaska are in favor of the defendant doctor.

In conclusion, this is without a doubt the most offensive example of self-interest legislation proposed in the last 25 years in Alaska. It is utterly without any reliable factual support for the premise of its proposed utility. It will only serve to benefit the insurance industry and those physicians who engage in negligent and sometimes reckless misconduct. While there are relatively few cases filed in this state alleging medical malpractice, this legislation will severely impact if not entirely eliminate a substantial portion of legitimate and worthy claims. It will leave horrifically injured patients and their families with a lifetime of misery, pain, and suffering with no remedy.

There is a substantial statistical chance that this legislation will affect one or more of you or a member of your family on a very personal basis during your lifetime. When you consider that it is estimated by health care safety monitors in Alaska that over 30 percent of providers don't even wash their hands before examining a patient, the chances of negligently passing on infectious disease is very high. [34] At least consider your safety and the safety of others before passing this grossly unfair legislation.

Very Truly Yours,

The Alaska Action Trust
Melissa Fouse, Executive Director

---

32 "Hype Outraces Facts in Malpractice Debate," *USA Today*, March 3, 2003.

33 American Medical Association, *Socioeconomic Characteristics of Medical Practice*, 2000 as quoted from N.C. trial lawyer expose.

34 Anchorage Daily News, March 2, 2004, Page D-1 "Patient Power"

24-LS0393\A.1
Bullock
2/11/05

AMENDMENT

OFFERED IN THE SENATE BY SENATOR ELLIS

TO: SB 67

Page 3, line 1:

Delete "$250,000"

Insert "$850,000"

Page 3, line 17:

Delete "$250,000"

Insert "$850,000"

Alaska Action Trust

P.O. Box 102323 • Anchorage, Alaska 99510
Office: 813 West Third Avenue • Anchorage, AK 99501
(907) 258-4040 • FAX (907) 258-8751

February 9th, 2005

The Honorable Con Bunde
Alaska State Senate
Capitol Building, Room 506
Juneau, Alaska 99801

Dear Senator Bunde:

During the Senate Labor & Commerce Committee hearing on Senate Bill 67, a committee member requested a list of the members of the Alaska Action Trust from Mr. Les Syren. The Alaska Action Trust is a sister non-profit 501 c (6) to the Alaska Academy of Trial Lawyers. Upon joining the Academy, an attorney is also a member of the Trust. The purpose of the Alaska Action Trust is education and outreach on justice policy matters; part of that outreach includes lobbying.

The membership list can be found at www.alaskatriallawyers.org.

Please do not hesitate to contact me if I can be of any further assistance.

Very Truly Yours,

Melissa Abel Fouse
Executive Director

Cc:
Senator Ralph Seekins
Senator Ben Stevens
Senator Bettye Davis
Senator Johnny Ellis

Malpractice Insurance Comparables

Arizona Compared With Other States For: General Surgeons, Internists, and OB/Gyn

	State	Internist Rates 2004		State	General Surgeon Rates 2004		State	OB/Gyn Rates 2004
1	FL	$69,310	1	FL	$277,241	1	FL	$277,241
2	MI	$63,898	2	MI	$193,819	2	IL	$230,428
3	IL	$58,514	3	IL	$183,560	3	PA	$172,178
4	OH	$41,998	4	PA	$135,406	4	TX	$165,054
5	PA	$36,873	5	MO	$132,314	5	MI	$164,934
6	TX	$36,018	6	OH	$130,813	6	OH	$152,109
7	CT	$28,917	7	TX	$128,239	7	CT	$148,164
8	WV	$27,499	8	NY	$108,466	8	MO	$147,406
9	MO	$27,088	9	NV	$85,928	9	NY	$146,615
10	NY	$25,091	10	NJ	$83,549	10	NV	$133,904
11	NJ	$23,818	11	DE	$83,079	11	WV	$128,331
12	NV	$23,734	12	WV	$79,975	12	NJ	$128,304
13	DE	$21,302	13	WY	$69,250	13	MD	$127,201
14	CA	$20,283	14	CA	$68,007	14	NC	$111,149
15	WY	$20,029	15	MD	$67,022	15	MA	$105,006
16	MD	$19,911	16	CT	$65,198	16	VA	$103,651
17	NC	$19,146	17	NC	$65,147	17	DE	$93,091
18	GA	$17,547	18	WA	$59,418	18	RI	$92,134
19	MS	$17,046	19	UT	$57,796	19	CA	$89,953
20	LA	$16,548	20	MS	$57,710	20	WY	$87,527
21	**AZ**	**$16,502**	21	GA	$56,958	21	KY	$85,658
22	WA	$15,869	22	NM	$56,639	22	LA	$82,259
23	VA	$15,158	23	KY	$56,538	23	GA	$82,210
24	MA	$12,908	24	VA	$55,223	24	MS	$82,108
25	AK	$12,812	25	LA	$52,944	25	UT	$81,628
26	CO	$12,711	**26**	**AZ**	**$51,188**	26	CO	$80,572
27	NM	$12,586	27	MT	$48,249	27	MT	$80,199
28	KY	$12,533	28	CO	$47,863	28	WA	$71,994
29	RI	$11,812	29	RI	$44,886	29	NM	$70,808
30	OR	$11,353	30	AK	$41,289	30	OR	$70,386
31	MT	$11,306	31	SC	$40,950	31	AK	$70,348
32	OK	$11,050	32	OR	$40,756	**32**	**AZ**	**$67,027**
33	NH	$10,935	33	NH	$40,110	33	NH	$61,773
34	UT	$10,801	34	TN	$39,570	34	HI	$61,684
35	ND	$10,502	35	MA	$39,474	35	TN	$59,571
36	HI	$10,284	36	IN	$37,152	36	IN	$58,020
37	KS	$10,276	37	HI	$37,012	37	KS	$51,835
38	ID	$9,906	38	OK	$35,455	38	VT	$51,585
39	IN	$9,776	39	KS	$34,248	39	ID	$48,251
40	WI	$9,570	40	ID	$34,192	40	SC	$47,739
41	IA	$9,350	41	ND	$30,917	41	IA	$47,174
42	SC	$9,094	42	IA	$30,636	42	AL	$41,737
43	AR	$8,897	43	AL	$30,515	43	AR	$41,103
44	TN	$8,710	44	AR	$29,026	44	OK	$40,392
45	MN	$8,006	45	MN	$27,749	45	ME	$37,663
46	AL	$7,484	46	SD	$23,382	46	WI	$36,742
47	SD	$7,320	47	ME	$22,830	47	ND	$36,179
48	VT	$7,237	48	WI	$21,727	48	MN	$34,158
49	ME	$7,206	49	VT	$21,347	49	SD	$28,578
50	NE	$3,478	50	NE	$14,819	50	NE	$22,682

Notes:

1. Rates are based on the *Medical Liability Monitor*, October 2004, Vol. 29, NO. 10.

2. Ranking is by state, based on the highest rate reported in each state for each speciality.

3. Arizona's rates are MICA's rates.

50STATECOMPARISON.xls

Division of Insurance

FISCAL NOTE

STATE OF ALASKA
2005 LEGISLATIVE SESSION

Fiscal Note Number:
Bill Version: SB 67
() Publish Date:

Revision Date/Time (Note if correction):
Dept. Affected: Commerce
Title: Claims Against Health Care Providers
RDU: Occupational Licensing (117)
Component: Occupational Licensing
Sponsor: Seekins
Requester: Senate Labor & Commerce
Component No.: 2360

Expenditures/Revenues (Thousands of Dollars)

Note: Amounts do not include inflation unless otherwise noted below.

OPERATING EXPENDITURES	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants & Claims						
Miscellaneous						
TOTAL OPERATING	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
CAPITAL EXPENDITURES						
CHANGE IN REVENUES (1156)	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

FUND SOURCE (Thousands of Dollars)

1002 Federal Receipts						
1003 GF Match						
1004 GF						
1005 GF/Program Receipts						
1037 GF/Mental Health						
1156 - Receipt Supported Services						
TOTAL	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**

Estimate of any current year (FY2005) cost: 0.0
Mark this box (X) if funding for this bill is included in the Governor's FY 2006 budget proposal:

POSITIONS

Full-time						
Part-time						
Temporary						

ANALYSIS: *(Attach a separate page if necessary)*

This legislation has no impact on the operations of the division.

Prepared by: Jennifer Strickler, Administrative Manager
Phone: (907) 465-2144
Division: Occupational Licensing
Date/Time: 2/4/05 5:59 PM
Approved by: Edgar Blatchford
Date: 2/4/2005
Agency: Commerce, Community, and Economic Development

(Revised 9/23/2004 OMB)

For SB67

AARP Alaska

February 8, 2005

The Honorable Con Bunde Chair
Senate Labor and Commerce Committee
Alaska State Capitol, Room 506
Juneau, Alaska 99801-1182

RE: SB 67 (Seekins)—Oppose Unless Amended

Dear Chair Bunde:

On behalf of the AARP members in Alaska, we ask that you and your colleagues on the Senate Labor and Commerce Committee oppose SB 67, authored by Vice-Chair Seekins, unless it is amended.

The issue of medical malpractice is often perceived as a battle between trial lawyers and insurance companies and physicians. We think it is also important to consider the victim of malpractice as well as **the ultimate goal of medical error reduction.**

AARP believes that state legislatures should not place limits on the amount of punitive damages or on joint and several liability, or unreasonable limits on damage awards for pain and suffering. We believe that a cap of $250,000 is, on its face, unreasonable.

For a cap to be reasonable, it would:

- Start at a level based on current conditions, not the arbitrary $250,000 figure chosen in California some 20 years ago,
- Provide flexibility for different types of cases,
- Include exceptions for egregious cases,
- Be indexed for inflation, and
- Be tied to other reforms, including mandatory error reporting and prompt payment requirements.

We oppose caps on punitive damages because these awards are relatively rare and generally imposed only in the most egregious cases, and thus are not a significant factor in malpractice premium problems.

3601 C Street, Suite 1420 | Anchorage, AK 99503 | toll-free 866-227-7447 | 907-341-2270 fax | toll-free 877-434-7598 TTY
Marie F. Smith, President | William D. Novelli, Chief Executive Officer | www.aarp.org/ak

It's not just physicians who need malpractice reform. Consumers injured by medical errors are also served badly by the tort system, and real reform requires going beyond the doctor vs. lawyer debate.

The tort system does a poor job of compensating people injured by medical errors. It is slow, expensive, and most injured people get nothing at all. The tort system also encourages providers to cover up mistakes in order to avoid lawsuits, rather than report errors in order to learn how to prevent them in the future.

We need to move beyond the debate over caps. Proposals to set unreasonable limits on pain and suffering awards do not help injured people get compensation or reduce errors. In fact, such caps can make it even harder for people who are injured to get fair compensation. AARP believes they are also unfair to older people with limited income potential who thus get little in economic damages.

Real reform should lead to fair compensation and error reduction. The Institute of Medicine (IOM) has proposed demonstration projects to test reform designed to fix what is broken for consumers. IOM has proposed testing non-judicial, no-fault alternatives to the tort system for medical errors (but not for other types of harm to patients, such as nursing home negligence). These alternatives could foster fair compensation and error reduction—what we believe should be the goals of consumer-oriented reform.

Under the IOM proposal, people with legitimate cases of medical injury could be identified and compensated appropriately. Payments would be based on "avoidability" of errors rather than "negligence." Amounts would be preset in schedules for specific categories of errors, which would provide reasonable limits that may help stabilize malpractice premiums. Health providers would have to report errors and make payments promptly, which would help injured people get fair compensation.

Errors could be reduced so fewer people would be injured. By requiring providers to report errors, the IOM claims that experts would be able to analyze system-wide errors and find ways to prevent them. The result would be a system in which patient safety is continually improved. With fewer errors, the cost of compensating injured people could decline.

We assume that reducing medical errors is in the best interest of all Alaskans and is the real intent of Senator Seekins in SB 67. We encourage you and your colleagues on the Senate Judiciary Committee to amend SB 67 to reflect the recommendations of the Institute of Medicine. Fair compensation and error reduction—AARP thinks we can all live with that.

Should you have any questions about our position, please feel free to contact me (586-3637), or Patrick Luby, AARP Advocacy Director (907-762-3314).

Thank you for your consideration.

Sincerely,

Marie Darlin

Marie Darlin, Coordinator
AARP Capital City Task Force
415 Willoughby Avenue, Apt. 506
Juneau, AK 99801
586-3637 (voice)
463-3580 (fax)

CC: Vice-Chair Ralph Seekins
Senator Ben Stevens
Senator Johnny Ellis
Senator Bettye Davis

FOR SB67

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

February 8, 2005

Honorable Con Bunde and
Senate Labor and Commerce Committee
Alaska State Senate
State Capitol, Room 506
Juneau, AK 99801

Re: SB 67 – Medical Liability Reform

Dear Senate Bunde and Senate Labor and Commerce Committee Members:

The Alaska State Medical Association (ASMA) represents physicians statewide and is primarily interested in ensuring that Alaska's citizens have access to high quality health care. ASMA strongly supports SB 67, which provides for meaningful medical liability r form and urges you to support it as well.

SB 67 establishes a $250,000 maximum for the unquantifiable damages known as non-economic damages. Non-economic damages are also known as "pain and suffering" damages. SB 67 does not limit the quantifiable economic damages such as lost wages, and post and future medical care costs. (SB 67 defines economic damages, which are not currently defined in Alaska statutes.)

ASMA asserts that enactment of SB 67 will provide for equitable and more predictable settlements in medical injury cases. The result will be a more stable professional liability insurance marketplace and, most importantly, will help us recruit physicians to help fill our chronic shortage of physicians.

The American Academy of Actuaries[1] has stated that medical liability reform establishing a $250,000 limit is imperative in stabilizing the physician professional liability insurance marketplace. A recent study[2] of medical students found the legal environment and the availability of affordable liability insurance plays a major part in a graduate's decision as to where to set up practice.

Access to medical services is limited in much of the state. Alaska has one of the smallest numbers of physicians per capita in the country. An American Medical News story pertaining to the special Medical payment reform for Alaska noted our precarious situation: "Alaska has long ranked among the worst states in terms of physician supply. In 2002, the state had fewer than 1,350 doctors in private practice and another few hundred in the military or other government posts…only six states had a lower doctor to patient ratio."[3] This data indicates that to reach the national average, Alaska would need about 500 more actively practicing physicians. This determination is future substantiated in Molly Southworth, MD, July 2004 Masters of Public Health Thesis, titled "Alaska's Physician Workforce: An Overview, a Summary of Training Background, and the Impact of the WWAMI Program".[4] Exacerbating the problem is the aged physician workforce. ASMA's database shows nearly 50% of our physician workforce over age 50. Dr. Southworth's Thesis[5] as well as Leslie Gallant of the State Medical Board[6] further validates that fact. The Providence Alaska Medical Center confirmed in its 2002 study that physicians in its service area were getting older and highlighted immediate acute shortages in psychiatrists, surgeons, and general internists, among

others.⑦ In 2002, the total shortage identified in primarily the Anchorage bowl area totaled about 200. The Providence study was updated for 2005 and projected the physician workforce needs to 2009.⑧ The Shortage in 2005 is still at around 200, with a projected shortage in 2009 of 261.

The recruitment challenge is the main reason medical liability reform is so important to Alaska. Unfortunately, the state does not have the capacity to "grow" its own physicians. Alaska has no medical school, and of the small number of students graduating annually from the WWAMI program, some do not return to practice. Likewise, the state's lone residency training program is small. Alaska is, and will continue to be a net imported of doctors. As such, we have to compete with other states facing physician shortages, a competition that is influenced significantly by the state's medical-legal practice environment.

ASMA asserts that SB 67 is a critical element in helping us improve our practice environment so as to help in physician recruitment. Well trained physicians in sufficient numbers are ASMA's greatest concern so that all Alaskans have access to high quality care when it is needed. Alaskans need and deserve local health care without having to be flown out of state for treatment.

ASMA urges you to support SB 67.

Sincerely,

Paul Worrell, MD

By: Paul Worrell, MD President
For: The Alaska State Medical Association

cc: Senator Ralph Seekins
Senator Ben Stevens
Senator Johnny Ellis
Senator Bettye Davis

Footnotes:

① Issue Brief, American Academy of Actuaries, "Medical Malpractice Tort Reform: Lessons from the States", Fall, 1996, p. 4.
② "AMA Survey: Medical Students' Opinions of the Current Medical Liability Environment: American Medical Association Division of Market Research and Analysis, November 2003.
③ "Medicare Law Aims to Bring Alaska Physicians in from the Cold." AM News, 1/19/2004.
④ "Alaska's Physician Workforce: An Overview, A Summary of Training Backgrounds, and the Impact of the WWAMI Program", Molly B. Southworth, MD, 7/2004, Masters of Public Health thesis, pp 26-33.
⑤ See Southworth ④, pp 12-14.
⑥ "Shingle Shortage?", Anchorage Daily News, Ann Potempa, 9/3/2002
⑦ "Physician Workforce Analysis", Providence Health System Alaska, November 2002, pp 17-18.
⑧ "PAMC Physician Supply and Physician Need Estimate: Summary", Providence Alaska Medical Center, February 2005.

Alaska State Medical Association

4107 Laurel Street • Anchorage, Alaska 99508 • (907) 562-0304 • (907) 561-2063 (fax)

February 22, 2005

Honorable Con Bunde
State of Alaska, Senate
Chair, Senate Labor and Commerce
State Capitol, Room 506
Juneau, AK 99801

Re: SB 67 – Data Requests

Dear Senator Bunde:

Thank you for the opportunity to provide testimony before your committee last Tuesday, February 8.

During the course of my testimony, there were several requests for more data. The requests for information fell into three areas:

1. Number of physicians actually practicing in Alaska;
2. States that have capped non-economic damages; and
3. The results of having capped non-economic damages.

Attachments 1 and 2 provide data regarding the first data request area. Attachment 1 is from the ASMA physician database and may differ from other sources as the data depicts a "snapshot" at a certain time. Attachment 2 are pages 26 -33 from Molly Southworth, MD July 2004 Masters in Public Health thesis, which I referenced in my testimony.

Attachment 3 is a chart found in the journal Medical Economics, page 26, January 7, 2005 issue. This chart outlines in general terms the caps on non-economic damages adopted in 22 states that have specified caps on non – economic damages.

Attachment 4 is comprised of pages 23 – 36 of the AMA publication "Medical Liability Reform – NOW!" December 3, 2004. This attachment provides information pertaining to the results of capping non-economic damages. Page 24 references the statistics I referred to regarding the relative increases in premiums in California compared to the rest of the country. This states the premium in California increased 167% versus 505% in the rest of the country for the period of 1976 to 2000. (This was determined by the National Association of Insurance Commissioners). The increases for 1976 to 2001 were 182% and 596% respectively.

In some states with recent enactments it is too early to tell the impact. One of the major insurers in Texas dropped its rates the first year following enactment of caps on pain and suffering by 12%. Perhaps more telling is that prior to enactment 13 of the 17 insurers offering professional liability coverage quit doing business in Texas. Since enactment, 9 insurers have sought to come back into the

Data Requested at Previous Meeting

marketplace. Also, it's too early to tell the affect in Idaho, which rolled back its cap in 2003 to $250,000. However, I believe it is noteworthy that two insurers that stopped providing coverage in Alaska have continued to provide coverage in Idaho (CNA and Northwest Physicians Mutual).

Please let me know if I may be of any further assistance.

Regards,

James Jordan,
Executive Director

1.

Physicians in Practice in Alaska

ASMA Database as of:	(1) Private Practice	(2) Other①	(3) Total Physicians Practicing in AK②	(3) Population	(5) Private Practice Physicians per 1,000 Residents	(6) Total Physician per 1000 Residents
1/85	567	227	794	543900	1.04	1.46
1/86	625	226	851	550700	1.13	1.55
1/87	567	227	794	541300	1.05	1.47
12/30/87	618	228	846	535000	1.16	1.58
12/30/88	614	228	842	538900	1.14	1.56
12/31/89	603	234	837	553171	1.09	1.51
12/31/90	603	234	837	569054	1.06	1.47
1/31/92	625	236	861	586722	1.07	1.47
1/31/93	661	302	963	596906	1.11	1.61
1/31/94	731	245	976	600622	1.22	1.62
12/31/94	777	215	992	601581	1.29	1.65
1/31/96	826	222	1048	605212	1.36	1.73
12/31/96	908	228	1136	609655	1.49	1.86
12/31/97	945	196	1141	617082	1.53	1.85
12/31/98	977	187	1164	622000	1.57	1.87
12/31/99	1024	221	1245	627576	1.63	1.98
12/20/00	1036	210	1246	632674	1.64	1.97
12/20/01	1080	199	1279	641482	1.68	1.99
12/04/02	1115	191	1306	648818	1.72	2.01
12/04/03	1164	180	1344	-	-	-
1/04	1191	116	1307			

Source: ASMA Data Base as reported in the Medical Directory published 1986 through 2004

* Other includes Public Health Service, Federal, Military, Municipal, and State employed physicians.

② ASMA Data Base includes only physicians actually in Alaska. The State Medical Board data contains those physicians actually in Alaska as well as those who maintain an Alaska license but live and practice ielsewhere.

① The ASMA Medical Directory is widely used by physicians, hospitals, and others. Physician seek to have their most up-to-date data in and ASMA Medical Directory because of its wide use for referral from one physician to another.

④ According to James Thompson, MD, President and CEO of the Federation of State Medical Boards of the U.S. (FSMB) : The number of licensed physicians in a state is not an accurate measure of whether patients have adequate access to health care. Physicians may reduce their practice, stop treating high-risk patients, or stop practicing altogether and still maintain their license. Also, the number of licensed physicians is not an accurate indicator of the distribution of those physicians in underserved areas. Licensed physicians may work in administrative, academic or other settings where they may not have a clinical practice. Also, many retired physicians maintain a license. Information in the Federation of State Medical Boards' database shows that approximately 60% of physicians are licensed in more than one state which indicates that they are licensed in states where they do not maintain a full-time or part-time practice.

IV. Discussion

1. An Overview of Alaska's Physician Workforce

The Size of Alaska's Physician Workforce

The current study confirms a considerable increase in physician manpower in Alaska in recent years but also suggests an ongoing need to focus on the training, recruitment, and retention of physicians for Alaska. Thoughtful analysis of the situation may actually suggest that the distribution and accessibility of physicians, as well as certain factors such as provider longevity, level of skill, efficiency of care, and other factors affecting the quality of care but beyond the scope of this analysis, may now be even more critical issues than the need to continually increase the total number of physicians.

These data demonstrate that as of July 2002, there were 1340 physicians or 214 physicians per 100,000 population who were both residing and holding active licenses to practice medicine in Alaska. This approximation[1] of the number of Alaska's physicians who reside and practice within the state may be compared to AMA data showing 286 nonfederal[2] allopathic physicians per 100,000 population in the US overall, as of 2001 (4). Even including osteopathic physicians and federal physicians who hold

[1] This approximation of the number of practicing physicians is assumed to be a bit high since we have not excluded inactive or non-patient care physicians, nor have we accounted for part-time workers; however, we also have not counted military physicians not licensed in Alaska, who provide care to a considerable number of military personnel and their dependents.

[2] The majority of US physicians (97.4%) are employed outside of the federal government (4), although the Indian Health Service has had many federal employees in Alaska over the years, a number recently declining.

Alaska licenses, groups not included in the AMA data, this suggests that there are 25.2 % fewer physicians per 100,00 civilian population in Alaska than in the US as a whole. According to AMA data for Alaska, the state of Alaska has 30.1% fewer allopathic, nonfederal physicians per 100,000 population than the US as a whole, and Alaska ranked as the 46th state in the nation regarding number of physicians per 100,000 population in 2001 (4). Table 7 displays data from this study, the AMA (4), and Johnson and Larson (13) for comparison, suggesting that Alaska, according to all of these sources, has 17-30 % fewer physicians than the US as a whole.

Table 7. Number of Alaskan Physicians per 100,000 Population: A Comparison of Three Sources, each using slightly different data criteria.

Data Source	Date of Data	Absolute Number of Physicians	Physicians per 100,000 Pop. in Alaska	Physicians per 100,000 Pop. in US	% Diff AK Physicians per 100,000 vs. US
Current Study	2002	1340 (iv.)	214 (i.), (iv.)	–	-25.2 % (vii.)
AMA (4)	2001	1267 (v.)	200 (ii.), (v.)	286 (v.)	30.1 %
Johnson & Larson (13)	2000	-	169 (iii.), (vi.)	204 (vi.)	17.2 %

(i.) based on population of Alaska 626,932 as per US Census 2000 (2)
(ii.) based on population of Alaska 635,000 as used by AMA (4).
(iii.) based on population of Alaska 625,039 as used by Johnson and Larson (13).
(iv.) all physicians, allopathic and osteopathic, with current license and Alaskan address of record with AK DOL; includes federal physicians, residents in training, and inactive physicians who hold active Alaskan licenses
(v.) allopathic nonfederal physicians only, including residents in training
(vi.) allopathic and osteopathic nonfederal physicians, excluding inactive physicians and physicians in training except for DO's in training
(vii.) compared to the AMA national data revealing 286 allopathic, nonfederal physicians per 100,000 in U.S. overall.

Numbers of nonfederal physicians per 100,000 civilian population (4) for the ten states with the lowest physician to population ratios and the five with the highest ratios are shown in Table 8 for comparison with the Alaska situation. Similar data (4) for the five WWAMI states are shown in Table 9. Finally, Table 10 shows number of civilians per nonfederal physician by state in the five WWAMI states for selected years starting in 1975 (4), the year that physicians began to graduate from the WWAMI Program, of course making their appearances in practice some years later.

Table 8. Numbers of Physicians per 100,000 Civilian Population in the Ten Lowest Ranking States and Five Highest Ranking States/D.C. in 2001 (data from AMA (4)).

State or D.C	Number of Physicians per 100,000 Civilian Population	Rank (of 51)
Idaho	179	51
Oklahoma	185	50
Mississippi	185	49
Nevada	197	48
Wyoming	199	47
Alaska	200	46
Iowa	203	45
Arkansas	212	44
Texas	219	43
Alabama	219	42
Connecticut	393	5
Maryland	409	4
New York	413	3
Massachusetts	453	2
District of Columbia	723	1

Table 9. Numbers of Physicians per 100,000 Civilian Population in the WWAMI States in 2001 (data from AMA (4)).

State	Number of Physicians per 100,000 Population	Rank (of 51)
Washington	281	17
Wyoming	199	47
Alaska	200	46
Montana	246	30
Idaho	179	51

Table 10. Number of Civilians per One Nonfederal Allopathic Physician in the WWAMI States in Selected Years since the Inception of the WWAMI Program (data from AMA(4)).

State	Civilians per one nonfederal allopathic physician (AMA)			
	1975	1985	1995	2001
Washington	594	449	386	356
Wyoming (i.)	923	714	569	503
Alaska	1,047	732	612	501
Montana	863	644	468	406
Idaho	965	751	617	559

(i.) Wyoming joined the WWAMI Program in 1996 with its first graduates in 2001, none yet in active practice in 2001.

These data suggest that numbers of physicians per population have increased significantly in Alaska in recent years but also that Alaska, several of the other non-Washington WWAMI states, and also a number of other rural states still tend to lag behind much of the nation in terms of total numbers of physicians relative to the population. While one would not expect these states to rank among the highest in the nation, given the absence of major national referral centers within them, these numbers would seem to confirm an

ongoing need to focus on the provision of physician manpower to these states. In fact, the inefficiencies of the provision of care to populations widely scattered over large areas plus the well-known increased medical needs of rural residents (12) might suggest that rather high numbers of providers per 100,000 population would be needed in these large states with sparsely scattered, rural populations.

Urban vs. Rural Distribution of Alaska's Physicians

Although the total number of physicians in Alaska has been increasing in recent years, maldistribution of physicians between urban and rural areas continues to be a major concern. These data show that in Alaska, 75.4% of physicians are in urban areas, defined here as including Anchorage, Fairbanks, and Juneau, while 24.6% of physicians are in rural locations. While a greater percentage of Alaska's physicians are in rural areas than physicians nationwide, even using this much more strict definition of rural for Alaska, (24.6% vs 13.8 % (4)), Alaska also has a relatively larger rural population with approximately 47%[3] of its population in small rural areas, while only approximately 20% of the total US population lives in rural areas (15).

As recently discussed by Larson and Hart (14), a better sense of the difference between urban and rural workforce can be gleaned by comparing

[3] Based on population data from the State of Alaska Department of Community and Business Development Community Information Summaries (21).

numbers of generalists per population in urban vs. rural areas. These data identify only 71 generalists per 100,000 population in rural Alaska compared to 100 generalists per 100,000 population in Alaska's urban areas, 29% fewer generalists per 100,000 population in rural areas as compared to Alaska's three largest cities. This difference is even more striking when we consider that rural residents tend to have more health care needs than urban residents (12), that many urban specialists do also provide some primary care, and that the provision of care to a widely scattered rural and remote population may be quite inefficient. Thus, maldistribution of physicians in Alaska remains an important issue, in spite of the increasing total number of physicians in the state.

Larson and Hart (14) have also recently discussed the fact that there are often also intrarural variations in availability of care that may be obscured by aggregate data such as these. This is particularly true in Alaska. Even with 71 primary care providers per 100,000 population in rural areas, Alaskans are well aware that many residents of the state must travel some distance, often by plane or boat, to reach even a single physician, and this assumes weather permits! This striking example of intrarural variation in physician availability will in some cases likely be a permanent situation in Alaska. It would be hard to imagine a remote village of <200 people ever having a full-time, in-residence physician, yet such villages are common in Alaska. Fortunately, the Alaskan Regional Native Health Care Corporations

(formerly Indian Health Service) have a quite well-developed system of 178 village clinics staffed by community health aides and, more recently, some mid-level providers in larger communities, to help ease this situation.

Improving the generalist to population ratio in some of the more rural and remote areas in Alaska is likely to be a continuing challenge. As described by Drickey (8) some 24 years ago after his experience practicing in Nome, Alaska, but little changed over time, the psychological stress of physical and medical isolation when making emergency, critical care decisions may be considerable; this is likely a factor in the choice of a rural vs. urban practice location for many physicians, particularly in Alaska where rural often means truly remote with transportation available only by plane or boat and only under good weather conditions. In fact, the strain of this sort of "medical isolation" might be added to an Alaskan version of the list of four factors generally considered to contribute to the difficulty of maintaining a rural physician workforce (19). The traditional four factors, sparse population, lack of cultural and physical amenities, poverty, and a population predominated by ethnic or racial minorities (19), may in fact be considered a plus by some rural Alaskan physicians[4], but facing the management of an acute, critical illness or injury requiring sophisticated critical care while alone in bad weather, with transportation out only at considerable expense and perhaps real risk to pilot

[4] This is not to suggest that poverty per se is considered a plus but that the opportunity to serve a population in poverty is considered a privilege by some Alaskan physicians.

and crew, in rural Alaska is never considered a blessing. When compounded by long spells of continuous 24-hour call schedules, a lack of colleagues with whom to discuss the joys and concerns of practice, the sometimes difficult politics and other issues of small communities, the lack of opportunity to participate in management of a wider range of medical cases as is often possible in an urban setting, and lesser income than seen in urban areas, it is hardly surprising that highly rural medical work is difficult to staff long-term. Factors such as improved transportation, the development of improved systems of referral and back-up consultative support for rural and remote physicians, plans to provide for physician "coverage" during absences for education and personal leave, the advent of telemedicine, and enhanced payment in underserved areas may also help relieve rural physician shortages in Alaska.

Gender Trends and Women Physicians in Rural Locations

Consistent with national trends, Alaska is experiencing an increasing number of women involved in the practice of medicine. As of July 2002, 404 of 1340 or 30.1% of physicians licensed and residing in Alaska were women. According to AMA data (4), 24.6% of allopathic physicians nationwide are women. Alaska would thus appear to have a slightly higher percentage of women physicians than does the nation as a whole.

These data also suggest an ever-increasing percentage of women physicians in Alaska. Of Alaskan physicians who have graduated since 1975,

ages. By 1986, moreover, 10 states had followed California's lead and placed caps on noneconomic damages.

How successful have all these reforms been? That question has fueled endless debate, complicated by the fact that, in at least 14 states, courts have overturned tort measures on constitutional grounds. (Tort-reform challenges are pending in three other states.)

Critics say the surviving reforms have failed to

States capping noneconomic damages

Here are the 22 states that cap noneconomic damages. For a more-comprehensive description of your state's cap, check with your medical society.

State	Cap amount	Year enacted
Alaska	$400,000 (Or life expectancy calculation, whichever is greater; rises to greater of $1 million or life expectancy calculation for severe injury.)	1997
California	250,000	1975
Colorado	300,000	1998 (amended 2003)
Florida	500,000 (May be increased to $1 million under certain conditions.)	2003
Hawaii	375,000	1976
Idaho	253,321*	1990 (amended 2003)
Kansas	250,000	1994
Maryland	635,000*	1986 (amended 1994)
Massachusetts	500,000	1997
Michigan	366,000* (There's a $653,500 limit for cases involving paralysis due to brain or spinal cord injury, impairment of cognitive capacity, or loss of reproductive ability.)	1993
Mississippi	500,000	2004
Missouri	565,000*	1988
Montana	250,000	1997
Nevada	350,000 (Cap may be raised in certain circumstances.)	2002
North Dakota	500,000	1996
Ohio	250,000 (Or three times economic damages, whichever is greater, up to a maximum of $350,000 for cases with single plaintiff or $500,000 for those with multiple plaintiffs.)	2002
Oklahoma	300,000	2003, 2004
South Dakota	500,000	1976
Texas	250,000	2003
Utah	430,000*	1996 (amended 2001)
West Virginia	250,000* (Rises to $500,000 in cases involving wrongful death, permanent and substantial physical deformity, and other serious injuries.)	2003
Wisconsin	432,352* (Doesn't apply to wrongful death cases, which carry different caps.)	1995

*Adjusts for inflation

Sources: Weiss Ratings, AMA, and National Conference of State Legislators

4.

II. Solutions

A. Studies and Expert Opinions Confirm that Certain Types of Reform Lower Costs and Improve Access

1. A study by Kessler and McClellan concluded that within three years after the enactment of direct tort reforms, including caps on non-economic damages, premiums in states with direct reforms declined by 8.4%.[50]

2. Another study by Stephen Zuckerman *et al.* looked at several types of reforms and concluded that capping medical liability awards reduced premiums for general surgeons by 13% in the year following enactment of that reform and by 34% over the long term. Premiums for general practitioners and Ob-Gyns were impacted similarly.[51]

3. In fact, not only do reforms lower physicians' premiums, they also lower medical expenditures, in general. In a different study by Kessler and McClellan, those researchers found "that malpractice reforms that directly reduce provider liability pressure lead to reductions of 5 to 9 percent in medical expenditures without substantial effects on mortality or medical complications."[52]

4. A study by the Agency for Healthcare Research and Quality (AHRQ) demonstrates a cap on non-economic damages helps protect patients' access to care.

   a. A July 3, 2003 study from the AHRQ[53] looked at the distribution of physicians across states with and without caps on non-economic damages since 1970. After adjusting for multiple factors, AHRQ found that by 2000, states with damage caps averaged 12% more physicians per capita than states without damage caps. (emphasis added)

   b. Additional key findings included: caps are effective in improving the supply of physicians and patients' access to care; and the lower the cap, the greater its effectiveness in ensuring patients' access to care.

5. A Joint Economic Committee study supports caps on non-economic damages.

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[50] Daniel P. Kessler & Mark B. McClellan, *The Effects of Malpractice Pressure and Liability Reforms on Physicians' Perceptions of Medical Care*, 60 LAW & CONTEMP. PROBS., 81-106 (1997).
[51] Stephen Zuckerman, Randall R. Bovbjerg & Frank Sloan, *Effects of Tort Reforms and Other Factors on Medical Malpractice Insurance Premiums*, 27 INQUIRY 167-182 (1990).
[52] DANIEL P. KESSLER & MARK B. MCCLELLAN, NAT'L BUR. OF ECON. ANALYSIS, DO DOCTORS PRACTICE DEFENSIVE MEDICINE?, 2 (1996), *available at* http://www.nber.org/papers/w5466.pdf .(last visited Feb. 3, 2004.
[53] FRED HELLINGER & WILLIAM ENCINOSA, U.S. DEP'T OF HEALTH AND HUMAN SERVS., THE IMPACT OF STATE LAWS LIMITING MALPRACTICE AWARDS ON THE GEOGRAPHIC DISTRIBUTION OF PHYSICIANS (2003).

a. In a study released in May 2003, the Joint Economic Committee of the U.S. Congress stated: "Some of the key reforms proposed at the federal level, including the cap on pain and suffering damages, have proven successful at producing savings when implemented."[54]

b. The study points to California, which under MICRA has a $250,000 cap on non-economic damages, allows for binding arbitration agreements, collateral source offsets, limits on contingency fees, advance notice of liability claims, statute of limitations, and periodic payment of damages. The Joint Economic Committee praises California as "perhaps the most successful example of reform at the state level," noting its slower rate of growth in medical liability premiums (167% versus 505% in the rest of the country from the period 1976 to 2000).[55]

c. After observing the failure of our current system to achieve either of its central goals, *i.e.*, to compensate those who are truly negligently injured and to deter negligent behavior, the study concludes: "This indictment of the tort system serves as the basis for medical liability reform…If adopted, the federal reform discussed here could yield budgetary savings of more than $19 billion per year, reduce the number of Americans without health coverage by up to 3.9 million, and lead to an environment that is significantly more receptive to efforts to improve patient safety and reduce medical errors."[56]

B. State Efforts to Enact Caps on Non-Economic Damages

1. Twenty-two states have enacted a cap on non-economic damages, while six states have a cap on total damages. Colorado places a cap on total damages and non-economic damages.

a. States with a cap on non-economic damages – Alaska, California, Colorado, Florida, Hawaii, Idaho, Kansas, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nevada, North Dakota, Ohio, Oklahoma, South Dakota, Texas, Utah, West Virginia, and Wisconsin. Maryland also has a $500,000 cap on non-economic damages in wrongful death actions.

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[54] JOINT ECON. COMM., 108TH CONG., LIABILITY FOR MED. MALPRACTICE: ISSUES & EVIDENCE 19 (2003).
[55] *Id.* Note: the updated figures through 2002, as calculated by the AMA according to NAIC data, are 245% and 750%, respectively. *See* NAT'L ASS'N OF INS. COMM'RS, PROFITABILITY BY LINE BY STATE BYLINE BY STATE IN 2002, 1976 and 2002 (National Association of Insurance Commissioners Insurance Products & Services Division 2003), at 116-7 (2003).
[56] JOINT ECON. COMM., *supra* note 54, at 24.

b. States with a cap on total damages – Colorado, Indiana, Louisiana, Nebraska, New Mexico, and Virginia.

2. A cap's effectiveness depends on the specific provisions of the legislation with which it was enacted.

For example, a state with a "hard" cap on non-economic damages should not be compared to a state with a "soft" cap on non-economic damages. A hard cap, like the $250,000 cap found in California's MICRA is not subject to exceptions, does not adjust over time, and applies irrespective of the number of defendants or plaintiffs. By contrast, a "soft" cap may be subject to numerous exceptions; increase annually with inflation, other economic indicators, or based on a set schedule; or apply individually to every defendant or plaintiff, thereby allowing several caps for a single claim.

a. Examples of states with a soft cap

i. Florida – Florida has a separate cap on non-economic damages for practitioners ($500,000) and non-practitioners ($750,000). The cap, however, increases to $1 million for practitioners and $1.5 million for non-practitioners if the negligence resulted in death or a permanent vegetative state or if the court found a manifest injustice would occur if the cap was not increased.

ii. Massachusetts – The $500,000 cap on non-economic damages in Massachusetts does not apply if the court finds the patient's injury resulted in substantial disfigurement or permanent loss or impairment, or if the court determines that other special circumstances warrant a finding that such limitation would deprive the plaintiff of just compensation for the injuries sustained.

iii. Missouri – The cap in Missouri increases with inflation. Originally set at $350,000 in 1986, the cap reached $565,000 as of February 1, 2004.[57] In addition, the Missouri law applies the cap individually to each defendant and each plaintiff. Missouri's cap was also considerably weakened by the courts in a 2002 decision, Scott v. SSM Healthcare, in which the court held that the cap can be applied separately for each act of medical liability. Therefore, if there are two separate and distinct "occurrences" of liability that contribute to a single injury the court can apply a

[57] MO. REV. STAT. § 538.210 (2004).