MINUTES

MONTANA SENATE
51st LEGISLATURE - REGULAR SESSION

COMMITTEE ON JUDICIARY

Call to Order: By Chairman Bruce Crippen, on April 5, 1989, at 10:00 a.m. in Room 325.

ROLL CALL

Members Present: Chairman Bruce Crippen, V. Chairman Al Bishop, Senators Bob Brown, John Harp, Mike Halligan, Joe Mazurek, R. J. Pinsoneault and Bill Yellowtail

Members Excused: Senators Tom Beck and Loren Jenkins

Members Absent: None

Staff Present: Staff Attorney Valencia Lane and Committee Secretary Rosemary Jacoby

Announcements/Discussion: Chairman Crippen announced the procedure for the Confirmation Hearing of Workers' Compensation Judge Timothy Reardon.

HEARING ON CONFIRMATION OF JUDGE REARDON

Presentation and Opening Statement by Sponsor: Rick Bartos, Chief Counsel for Governor Stan Stephens introduced Judge Timothy Reardon. He presented a written statement to the committee (Exhibit 1).

Testimony:

Judge Timothy Reardon spoke before the committee. He thanked Rick Bartos for the introduction and said he wanted to express his appreciation to Governor Stephens. He said he was aware of the consternation and concern expressed by the legislature during the last three sessions regarding the Workers' Compensation Commission. He said that Montana was not alone in the problems experienced with that issue, that other states were also experiencing difficulty. In his view, he felt that his role as judge was to decide disputes and he said he did what the law required.

Questions From Committee Members: Senator Mazurek asked Judge Reardon to comment on the Workers' Compensation Court

in general, its relevancy, and its manner of resolving claims.

Judge Reardon said he had testified before the Senate Labor Committee during the 1987 session. Reviewing the court, he said, was certainly appropriate. He felt the system could be improved, but he did not think a better alternative had been presented. There needed to be access to the courts, he felt, and speedy resolution was the best, particularly for claimants. Down the road with the changes made in recent sessions regarding the hiring of counsel, it may be that another look should be taken at the system, he commented. Restrictions made in 1987 on the awarding of attorney fees and access to counsel may make the formal system more formidable for claimants, he said. Presently, the system is expedient, he told the committee. He felt the system was a fair one, bringing speedy resolutions.

Senator Halligan asked how often Judge Reardon's decisions were appealed to the supreme court and how many times have they been reviewed.

Judge Reardon said that, up until about a year ago, it was about 40%-50%, and reviews about 70%. He believed that, in cases where reversals occurred, more occurred in favor of the claimant -- about 30%.

Senator Halligan asked, with the change in statute in 1987, taking out the liberal interpretation language, how would the judge change the way he voted.

Judge Reardon felt liberal construction was overused and he felt it hadn't played any role. He thought there was a perception that it was the basis of some claims prevailing, but it was never a conscious decision on his part, he said.

Closing by Sponsor: Senator Crippen closed the hearing.

## DISPOSITION OF CONFIRMATION HEARING

Discussion: Senator Mazurek commented that he had limited contact with the court, but had great respect for it.

Recommendation and Vote: Senator Mazurek MOVED that the nomination of Timothy Reardon as Workers' Compensation Judge be APPROVED. The MOTION CARRIED UNANIMOUSLY.

## HEARING ON HOUSE BILL 699

Presentation and Opening Statement by Sponsor:
Representative Kelly Addy of Billings, District 94, opened the hearing, saying it was the most important bill he had ever carried. He said the purpose of the bill was to provide patients assured compensation regarding claims against physicians who deliver babies. Representative Addy told the committee that, in 1985, 148 family practitioners delivered babies in Montana. At the end of 1988, that figure was down to 85. The dramatic drop is a difficult blow to Montana, especially in rural areas, he commented. The medical profession is caught in a dilemma. The medicare/medicaid reimbursement rate bases its payment rate on costs which is considered to be less in Montana. The other problem is a dramatic increase in malpractice premiums for doctors who deliver babies, he said. Montana's plight had even been related over the national news, he said

The bill attempted to provide a patients' assured compensation fund that would be divided into a primary pool and a secondary pool. The secondary pool was discussed on page 35 in Section 22 and was the "no fault" provision. This pool (the smaller of the two) provided that, on the initial visit or immediately after it, there would be a $25 assessment for each birth. That $25 would go into the secondary pool which would have been capitalized at $100,000. Everybody is in the secondary pool, unless they opt out, he explained. If a physician stays in the secondary pool, he said, it means that if there was a proven birth related defect (that it's related to the health care process in the delivery or birth process), the patient would be entitled to benefits at a certain level -- much like "no fault" insurance. The payments are figured largely like the Workers' Comp payments, he said.

If the claim is large and cannot adequately be recompensed out of the secondary pool, then the person can opt into the primary pool, with no limits on liability much like an insurance company being set up for baby doctors in Montana, he stated. If the patient wishes to opt into the primary pool, they file a claim in court or before the Medical-Legal Panel. That pool needs to be capitalized from what is equivalent to an interest-free source of money in the amount of $6.3 million at the outset of the program so that it can earn interest and provide funding for claims that come on early. He felt the first 4 years were crucial to the viability of the insurance program.

The bill originally provided for the $6.3 million fund to be raised by a one-time assessment against the annual premiums by property and casualty insurers at the rate of 1.17%. The subcommittee in Judiciary did not like that so they made it an interest-free loan, he said, from the general fund of $6.4 million. The bill was then referred to the Appropriations Committee and they didn't like that, so they amended the bill back to the 1.17% one-time assessment on premium. When the bill went back on the floor of the House, Rep. Marks asked how much money would be needed to be borrowed at 4% to arrive at the $6.3 million fund four years from the outset. That came out to about $7.35 million at 4%, he said.

Representatives Bardanouve and Spaeth seemed to object to that funding, he explained. So there is a funding mechanism in the bill at this time that will not work, he stated. He said that, if the money was to be raised from the general fund by a one-time assessment, it would have to be assessed at 1.47% against the general fund. The annual premiums for property and casualty carriers are larger than the general fund in the state of Montana. He suggested that another source of funding might be the Coal tax trust fund, but he felt the 3/4 required vote would not pass the House. He said it could be taken out of the 15% of the Coal Tax revenues that go into the in-state investment program now, which would require a majority vote.

He asked the committee to remember the doctor and the patient. The bill would provide a reduced premium rate and encourage doctors to remain in rural Montana. He said this was the one vehicle alive in the legislature which would help the situation. He urged passage of the bill.

List of Testifying Proponents and What Group they Represent:

Gary Neeley, Montana Medical Association, Counsel on Liability Matters
Michael Sadaj, M. D., Butte, Montana Medical Association
Andy Jergens, M. D., himself
Vicki Proctor, herself
Susie Bramlette, herself
Jim Ahrens, Montana Hospital Association
Allen Chronister, State Bar

List of Testifying Opponents and What Group They Represent:

Joseph Sabella, M. D., The Doctors' Company

Shelton Davidow, V. Pres., The Doctors' Company
Mike Sherwood, Montana Trial Lawyers Association
Jacqueline Terrell, American Insurance Association
Sue Weingartner, Montana Trial Defense Lawyers
Jim Penner, Montana Board of Investments
Dick Williams, Association of Montana Retired Public Employees

Testimony:

Gary Neeley (Exhibits 2, 3) said in addition to payment for insurance, doctors may also be required to purchase a policy for claims that may occur after they leave a practice which costs a considerable sum of money. A physician has a choice to drop the obstetrics coverage and receive about a 50% drop in premium rates. Many physicians have chosen to do this, or to retire early or move to a larger city.

He said that for the years 1977 through 80, there were 13 claims filed against O.B. physicians; for the period 1981 through 84, there were 74 claims; and for the years 1984 through 1988, there were 122 claims. There are declining physicians, declining infant mortality rate, declining maternal mortality rate, yet a rapid increase in obstetrical claims.

When a small town doctor leaves, the town not only loses an obstetrical services, but pediatric services, setting fractures, surgical procedures etc. Many hospitals are forced to close in small towns when the doctors leave. This proposal is an attempt to help the physician remain by helping reduce his premiums by 50% and dropping the limits to $100,000. He said the doctors would pay into the pool which would provide premium to provide the annual funding for the excess coverage pool providing coverage up to $300,000. He said that Section 10 has a mandated return of savings provision; so if a certain surplus is achieved, the excess must go to: 1/2 to the funder (so far the state) and 1/2 into the voluntary arbitration program.

He said that a number of states have insurance rates lower than Montana's. He felt the pool system would work, saying that people who were poor risks or were uninsurable couldn't get into the pool. It is also limited to doctors who deliver babies or who are obstetricians, he told the committee. There is one exception, he stated, and that was when a person takes a no fault track and attempts voluntary arbitration. Then that claim would be dealt with in the arbitration process if the claimant chose. Voluntary

arbitration on a "no fault" basis is available in two classifications: Small claims who don't have multi-million dollar's worth of damages or claims where no negligence and is provable on the part of an attorney.

An actuarial firm had put together rates he said and he presented charts to the committee. He said the funds had been deliberately over-funded. The only reason for the excess funds was in case the actuarial estimates turn out to be incorrect, he said. He presented Utah Medical Insurance claims paid out in Montana to the committee. He said that 2 obstetrical claims paid out $399,000 -- $383,196, with expenses of $16,590. If the mechanism of the bill had been set up, not only would the premiums set by the actuaries have been adequate to pay the two claims, but the pool would have money in excess from paying the premiums. He said the bill does have risks, but there are risks in doing nothing. He said that untold hours had put in by many people over a period of 14 months to study the legislation. He felt it was financially sound and urged passage of the bill.

Michael Sadaj said he was an internist whose practice was restricted to lung disease. He said there is a crisis. He pointed out that in Dade County, it costs from $150,000 to $200,000 for O.B. premiums. He said a doctor limited to family practice pays about $27,000 and an obstetrician pays $60,000 per year. His premium as an internist is about $8,000 with about 20% of that going to subsidize the obstetrical liability. In southwestern Montana in 1972, there were 29 physicians who delivered babies. The most recent count now is 8, he said.

Andy Jergens formerly a family practitioner who delivered babies and practiced in Dillon, quit his practice when informed that within 5 years, his insurance would increase by 250%, and he was paying $15,000 at that time. He felt the premiums would pass his income, so he felt no alternative but to quit. His father had delivered "several hundred thousand" (!) babies in Dillon, he had related in an interview with Charles Kuralt, and that he hated to give up the "most fun" part of the job.

Vicki Proctor and Susie Bramlette presented written testimony to the committee (Exhibits 5 and 6). They also presented a video to the committee which showed the stories of the doctor in Dillon who had quit his practice.

Jim Ahrens said that 15 hospitals in Montana no longer provide obstetrical services and another will quit during 1989. The lack of physicians delivering babies affects all

hospitals in Montana, he said. He said the problem not only affects the rural hospitals, but some in the larger cities. He urged careful consideration of the bill. He showed a video regarding the effect that the O. B. crisis had had on hospitals. It pointed out that 80% of family practitioners delivering babies in Montana this year would possibly go out of practice within the next year.

Allen Chronister said he was appearing neither as a proponent nor an opponent. He distributed written material to the committee (Exhibit 7).

Dr. Joseph Sabella appeared as an opponent and distributed material regarding the Doctors' Management Company. (Exhibit 4). He said the Doctors Company was started in 1976. Initial insurance was $75. It is not a stock company, he said. The owners are its policy holders. The board of governors are practicing doctors. The purpose of the company was to respond to the high malpractice rates and was an attempt at tort reform. He said they were in California and Nevada, and that they had attempted to keep premiums as low as possible. The company came to Montana in 1978 and accepted all specialties, he said. Montana doctors are served through an administrative group with 2% going to the Montana Medical Association -- approximately $80,000. A year ago family practice related to obstetrics was raised 10% and obstetricians were raised $15%, he related. They expected to ask for no rate increases in 1989.

Dr. Sabella told the committee that the bill was copied after Wisconsin, Indiana and Louisiana, which have funds that are working well. He said some states are in trouble with their funds, he said. He said the company had conducted a detailed, actuarial study and said it disagreed with the contention of some testimony that the bill was underfunded. He said his company had been in business for a long time and knew what they were doing. He disagreed with the savings as stated by Mr. Neeley. He said the fund would provide risks for patients and doctors. The fund would not be guaranteed, whereas policies through his company would be, he said. Should the fund go broke, there would be no funding. He said the MMA knows that the actuarial studies are different, would not save the doctors any money and would be in danger of insolvency. He said the Doctors Company had notified the MMA of that in February. He said that the next speaker would give additional information on the bill.

Shelton Davidow said that previous to his present position, he worked for the state government for 15 years doing

insurance committee analysis. He said he did not view the bill as workable on its face. He found a number of problems in the second drafting of the bill and wanted to call them to the attention of the committee. He reviewed the bill and found items of concern to him on p.7, , Section C; on p. 7 (2); on p. 13 through 15; on p. 17 and 18; on page 20, Section 11; in Section 16, Section 18; on p. 35, 36 37, 39. He distributed a letter from Gary Neeley to Brian Zins regarding a "quick fix" that was being attempted by the MMA (Exhibit 8). He called attention to marked paragraphs in the letter.

Dr. Sabella spoke again. He proposed a "Good Samaritan" law for rural areas, improved pre-natal care, said the medicaid reimbursement was too low, and suggested direct subsidies for doctors in rural areas.

Mike Sherwood presented written testimony to the committee (Exhibit 9)

Jacqueline Terrell opposed the bill and presented suggested amendments to the committee. (See Exhibit 10) Her association appreciated the problem of high insurance rates. She said she was the daughter of an obstetrician who hasn't delivered a baby in 20 years. She said the committee had been told that malpractice rates were based on national experience and not on Montana's experience. She said the only private insurance company writing insurance in Montana was the St. Paul Co., but does not write it based on national rates. It writes in only 42 states and Montana's rates are 35th lowest of those, she said. Her association's primary concern was addressed in subcommittee in the House, she told the committee, and that was the funding. She did not agree with the assessment on all property and casualty insurers in the state of Montana, which would increase all property premiums. She viewed that as unfair and asked for review of other kinds of funding.

Sue Weingartner presented written material to the committee and supported the bill ( Exhibit 11).

Jim Penner (Exhibit 12)

Dick Williams (Exhibit 13)

Questions From Committee Members: Senator Pinsoneault asked if told the district courts that the settlement agreement is sealed and is not public knowledge. Mr. Neeley said that the only who knew was the association. He said that

information had come from the Doctors Company. He gave the chairman Exhibit 15.

Mr. Sherwood said he hadn't quoted figures at the hearing, but that he had given figures to Rep. Addy at one point taken from the Insurance Service Office of America (ISO) which related to 1975 to 1984 for the state of Montana. He didn't have more recent figures, but those showed just over $150 million in premiums paid, and just under $14 million in benefits paid. Senator Pinsoneault said he knew there were some outstanding sealed verdicts in the state.

Senator Harp said he was concerned about the Board of Investment's involvement in the bill. He understood that pension money could not be included. He wondered where the money could come from. He said he thought statute prohibited direct loans.

Jim Penner said there were some problems in the legislation where it stated that the Board of Investments would fund the bill. The Board of Investments has no funds, so a specific fund would have to be named. Pension funds were out, as well as treasurer's fund. The only funds that could be realistically involved, he stated, were the Coal Trust funds and/or the in-state Coal Trust Fund. The Permanent Coal Trust Fund is predominately of corporate bonds and Montana loans with a definitely stated time for paying back the loans. Each loan is definitively collateralized. The in-state fund is a $60 million fund. There could only be a loan of 10% of the annual flow revenues into that fund, about $1 million. Statute also requires that those loans come from the financial institutions. The third problem would be that this would be a $7 million loan on a $60 million fund. He questioned whether that would reach the diversification level required by the "prudent expert" principle.

Senator Mazurek asked Mr. Neeley for comments on the actuarial testimony given. Mr. Neeley said he would provide a copy of that report for the committee. (See Exhibit 16)

Senator Mazurek said he didn't think the $100,000 fund for lawyers would be adequate. Mr. Neeley said that the Utah Medical Insurance figures show a loss expenses were $16,000 including claims investigations. None of those claims go into the arbitration pool, he said.

Senator Mazurek said he had concerns that the fund would work. Mr. Neeley said if the bill were put back in its original form, it would work. The House struck the

provisions that would provide "tail coverage" to be taken care of by the insurance companies.

Closing by Sponsor: Rep. Addy said that $36 million was being paid by Montana doctors every 10 years for malpractice. He said the attempt of the bill was to address that situation. He responded to Jacqueline Terrell's testimony by distributing Exhibit 14, which he said, told that the rates were based on nationwide malpractice claims. He said the legislature has the power of life and death with this bill. He urged the committee to consider the communities who are about to lose doctors, hospitals, cash flows in health care. He said he would be glad to work with any subcommittee that Chairman Crippen would select.

ANNOUNCEMENT:
Chairman Crippen said it was his intention to place the bill in a subcommittee with Senators Bishop, Mazurek and Halligan as members of the committee. He said the bill was a revenue bill and had to be acted upon as quickly as possible as the deadline for transmitting revenue bills was with in a short time.

NOTE: Exhibit 17 has been inserted. It is a summary of HB 699 prepared by Staff Attorney Valencia Lane as requested by Chairman Crippen.

Exhibit 18 is a copy of the Confirmation Hearing Agenda.

ADJOURNMENT

Adjournment At: 12:28 p.m.

SENATOR BRUCE D. CRIPPEN, Chairman

BDC/rj

minrj.405

ROLL CALL

JUDICIARY COMMITTEE

51st LEGISLATIVE SESSION -- 1989 Date 4-5-89

| NAME | PRESENT | ABSENT | EXCUSED |
|---|---|---|---|
| SENATOR CRIPPEN | ✓ | | |
| SENATOR BECK | | | ✓ |
| SENATOR BISHOP | ✓ | | |
| SENATOR BROWN | ✓ | | |
| SENATOR HALLIGAN | ✓ | | |
| SENATOR HARP | ✓ | | |
| SENATOR JENKINS | | | ✓ |
| SENATOR MAZUREK | ✓ | | |
| SENATOR PINSONEAULT | ✓ | | |
| SENATOR YELLOWTAIL | ✓ | | |
| | | | |
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| | | | |
| | | | |

Each day attach to minutes.

Ex 1

SENATE JUDICIARY
EXHIBIT NO. 1
DATE 4-5-89
BILL NO. Confirmation Hearing

State of Montana
Office of the Governor
Helena, Montana 59620
406-444-3111

STAN STEPHENS
GOVERNOR

March 28, 1989

The Honorable William Farrell, Chairman
State Administration Committee
Montana State Senate
State Capitol
Helena, MT 59620

Dear Senator Farrell:

I respectfully submit the biographical information for the following appointments:

As Workers' Compensation Judge in accordance with Section No. 2-15-1014, MCA.

Judge Timothy Reardon, Helena, Montana 59601, reappointed to serve a term ending July 1, 1993.

Judge Reardon received a bachelor's degree in English in 1970 from Carroll College, and his law degree from the University of Montana in 1973. He has completed courses in Administrative Law, Judicial Writing, and Casework Management for Senior Judges at the National Judicial College, University of Nevada at Reno. From 1973-1974 he was a staff attorney for the Department of Health and Environmental Sciences, serving as legal counsel to the Air and Water Quality Bureaus. From 1974-1976 he practiced part-time in his private law firm in Anaconda, Montana, while he also served as District Public Defender for adult and youth defendants. Reardon was Chief Legal Counsel to the Division of Workers' Compensation, Department of Labor and Industry, in Helena, from 1976-1980. He was first appointed Workers' Compensation Judge in 1981. Judge Reardon is a member of the State Bar of Montana, the Montana Judges' Association, and the International Association of Industrial Accident Boards and Commissions (IAIABC), as well as the Western Region IAIABC.

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Sincerely,

Stan Stephens

STAN STEPHENS
Governor

SENATE JUDICIARY
EXHIBIT NO. 1, p. 2
DATE 4-5-89
BILL NO. HB 699

# Montana State Senate

*The Big Sky Country*

WORKERS COMPENSATION COURT
CONFIRMATION HEARING

*******

APRIL 5, 1989

Old Supreme Court Chamber

10:00 A.M.

Room 325

MONTANA STATE CAPITOL

*******

By The

SENATE JUDICIARY COMMITTEE
Bruce C. Crippen, Chairman

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REAPPOINTMENT

OF

WORKERS COMPENSATION JUDGE .....TIMOTHY REARDON

Neely
Ex 2

SENATE JUDICIARY
EXHIBIT NO. 2
DATE 4-5-89
BILL NO. HB 699

1986: All Medical Malpractice

Montana Medical Malpractice: Carriers Currently Writing In Montana

| Company | PREMIUM + INVESTMENTS: Direct Premiums Earned | PREMIUM + INVESTMENTS: Allocated Investment Income | LESS: Direct Losses Paid | Remaining Balance |
|---|---|---|---|---|
| DR CO | $ 3,062,904 | $ 1,072,085 | $ 712,296 | $ 3,422,693 |
| UMIA | $ 682,511 | $ 251,985 | $ 578,815 | $ 355,681 |
| ST PAUL | $ 1,876,554 | $ 369,097 | $ 308,375 | $ 1,937,276 |
| ICA | $ 761,009 | $ 295,067 | $ 63,870 | $ 992,206 |
| TOTAL | $ 6,382,978 | $ 1,988,234 | $ 1,663,356 | $ 6,707,856 |

Data From Annual Statements Of Carriers On File With Commissioner Of Insurance Of Montana. Excludes AETNA Losses. AETNA No Longer Writes In Montana.

Neely Ex 3

SENATE JUDICIARY
EXHIBIT NO. 3
DATE 4-5-89
BILL NO. HB 699

Actual Paid Claims - Utah Medical Insurance Association

1982 - 1987, Montana Medical Malpractice Claims Only

| Claim | Indemnity | Expense | TOTAL | Incident Year | Closure Year |
|---|---|---|---|---|---|
| 1 | $175 | $0 | $175 | 1982 | 1982 |
| * 2 | $260,000 | $16,590 | $276,590 | 1982 | 1985 |
| 3 | $0 | $4,344 | $4,344 | 1982 | 1984 |
| 4 | $0 | $0 | $0 | 1983 | 1985 |
| 5 | $547 | $2,993 | $3,540 | 1983 | 1984 |
| 6 | $0 | $0 | $0 | 1982 | 1986 |
| 7 | $0 | $3,392 | $3,392 | 1983 | 1985 |
| 8 | $0 | $690 | $690 | 1983 | 1984 |
| 9 | $0 | $0 | $0 | 1983 | 1984 |
| 10 | $1,000 | $746 | $1,746 | 1984 | 1984 |
| 11 | $0 | $1,599 | $1,599 | 1983 | 1984 |
| * 12 | $123,196 | $0 | $123,196 | 1984 | 1985 |
| 13 | $260 | $0 | $260 | 1984 | 1984 |
| 14 | $78 | $3,490 | $3,568 | 1984 | 1984 |
| 15 | $37,500 | $12,773 | $50,273 | 1984 | 1986 |
| 16 | $37,500 | $0 | $37,500 | 1984 | 1986 |
| 17 | $22,500 | $8,813 | $31,313 | 1983 | 1986 |
| 18 | $17,500 | $10,526 | $28,026 | 1984 | 1986 |
| 19 | $500,000 | $1,259 | $501,259 | 1984 | 1986 |
| 20 | $0 | $1,993 | $1,993 | 1985 | 1985 |
| 21 | $0 | $4,238 | $4,238 | 1983 | 1986 |
| 22 | $15,000 | $371 | $15,371 | 1985 | 1987 |
| 23 | $0 | $5,450 | $5,450 | 1982 | 1986 |
| 24 | $0 | $819 | $819 | 1982 | 1987 |
| 25 | $0 | $0 | $0 | 1982 | 1986 |
| 26 | $7,500 | $0 | $7,500 | 1984 | 1986 |
| 27 | $0 | $0 | $0 | 1986 | 1986 |
| 28 | $2,168 | $0 | $2,168 | 1984 | 1986 |
| 29 | $0 | $637 | $637 | 1983 | 1986 |
| 30 | $0 | $3,400 | $3,400 | 1986 | 1987 |
| 31 | $0 | $291 | $291 | 1984 | 1987 |
| 32 | $0 | $1,217 | $1,217 | 1986 | 1987 |
| 33 | $0 | $865 | $865 | 1986 | 1987 |
| 34 | $5,000 | $0 | $5,000 | 1986 | 1987 |
| 35 | $8,500 | $125 | $8,625 | 1984 | 1987 |
| 36 | $69,000 | $4,664 | $73,664 | 1984 | 1987 |
| 37 | $0 | $1,668 | $1,668 | 1984 | 1987 |
| | $1,107,424 | $92,954 | $1,200,378 | | |

Actual Paid Claims - Utah Medical Insurance Association

1982 - 1987, Montana Medical Malpractice Claims Only

OBSTETRICAL MEDICAL MALPRACTICE

Indemnity & Expenses Paid: Number Of Claims And Average Paid By Two-Year Period, 1982 - 1987

| Closure Year | Indemnity Paid | Expenses Paid | Total Paid | Number Paid | Average Total |
|---|---|---|---|---|---|
| 1982-1983 | $ 0 | $ 0 | $ 0 | 0 | $ 0 |
| 1984-1985 | $ 383,196 | $ 16,590 | $ 399,786 | 2 | $ 199,893 |
| 1986-1987 | $ 0 | $ 0 | $ 0 | 0 | $ 0 |
| | $ 383,196 | $ 16,590 | $ 399,786 | 2 | $ 199,893 |

Compilation From Computer Printouts Of Utah Medical Insurance Association

ALL MEDICAL MALPRACTICE

Indemnity & Expenses Paid: Number Of Claims And Average Paid By Two-Year Period, 1982 - 1987

| Closure Year | Indemnity Paid | Expenses Paid | Total Paid | Number Paid | Average Total |
|---|---|---|---|---|---|
| 1982-1983 | $175 | $0 | $175 | 1 | $ 175 |
| 1984-1985 | $385,081 | $35,837 | $420,918 | 13 | $ 32,378 |
| 1986-1987 | $722,168 | $57,117 | $779,285 | 23 | $ 33,881 |
| | $1,107,424 | $92,954 | $1,200,378 | 37 | $ 32,442 |

Compilation From Computer Printouts Of Utah Medical Insurance Association

SCHEDULE P
STATE: MONTANA
AS OF DECEMBER 31, 1988

| | 1976 | 1977 | 1978 | 1979 | 1980 | 1981 | 1982 | 1983 | 1984 | 1985 | 1986 | 1987 | 1988 | TOTAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| PREMIUMS EARNED | 0 | 0 | 0 | 1,980 | 58,755 | 276,224 | 449,463 | 770,383 | 1,158,594 | 1,787,830 | 2,956,417 | 5,045,951 | 6,688,781 | 19,194,378 |
| PAID LOSSES | 0 | 0 | 0 | 0 | 120,000 | 314,792 | 145,375 | 217,806 | 724,349 | 1,213,879 | 861,869 | 547,931 | 70,390 | 4,216,391 |
| PAID ALAE | 0 | 0 | 0 | 0 | 21,732 | 94,765 | 126,700 | 100,803 | 96,286 | 310,425 | 219,692 | 187,808 | 109,656 | 1,267,867 |
| PAID ULAE | 0 | 0 | 0 | 0 | 30,629 | 32,869 | 30,519 | 24,520 | 94,536 | 188,108 | 175,352 | 180,260 | 156,944 | 913,736 |
| TOTAL PAID | 0 | 0 | 0 | 0 | 172,361 | 442,426 | 302,594 | 343,129 | 915,171 | 1,712,412 | 1,256,913 | 915,999 | 336,990 | 6,397,994 |
| UNPAID LOSSES: | | | | | | | | | | | | | | |
| CASE LOSS RESERVE | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 40,000 | 0 | 1,164,881 | 2,135,000 | 1,365,000 | 5,052,000 | 9,756,881 |
| ACTUARIAL ADDITION | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | (361,710) | (695,717) | 578,719 | (1,232,140) | (1,710,848) |
| ACTUARIAL IBNR | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 32,920 | 114,021 | 248,141 | 395,082 |
| TOTAL UNPAID LOSSES | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 40,000 | 0 | 803,171 | 1,472,203 | 2,057,740 | 4,068,001 | 8,441,115 |
| UNPAID ALAE: | | | | | | | | | | | | | | |
| CASE ALAE RESERVE | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3,679 | 0 | 35,795 | 70,801 | 130,014 | 613,790 | 854,079 |
| ACTUARIAL ADDITION | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 518,230 | 695,715 | 750,028 | 943,804 | 2,907,777 |
| ACTUARIAL IBNR | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 14,108 | 48,866 | 106,346 | 169,320 |
| TOTAL UNPAID ALAE | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3,679 | 0 | 554,025 | 780,624 | 928,908 | 1,663,940 | 3,931,176 |
| UNPAID ULAE | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 3,600 | 0 | 72,285 | 135,461 | 195,458 | 388,453 | 795,258 |
| TOTAL UNPAID | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 47,279 | 0 | 1,429,481 | 2,388,288 | 3,182,106 | 6,120,394 | 13,167,549 |
| INCURRED LOSSES | 0 | 0 | 0 | 0 | 120,000 | 314,792 | 145,375 | 257,806 | 724,349 | 2,017,050 | 2,334,072 | 2,605,671 | 4,138,391 | 12,657,506 |
| INCURRED ALAE | 0 | 0 | 0 | 0 | 21,732 | 94,765 | 126,700 | 104,482 | 96,286 | 864,450 | 1,000,316 | 1,116,716 | 1,773,596 | 5,199,043 |
| INCURRED ULAE | 0 | 0 | 0 | 0 | 30,629 | 32,869 | 30,519 | 28,120 | 94,536 | 260,393 | 310,813 | 375,719 | 545,397 | 1,708,994 |
| TOTAL INCURRED | 0 | 0 | 0 | 0 | 172,361 | 442,426 | 302,594 | 390,408 | 915,171 | 3,141,893 | 3,645,201 | 4,098,106 | 6,457,384 | 19,565,543 |
| OPEN CLAIMS | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 2 | 0 | 7 | 14 | 22 | 105 | 150 |
| CLOSED CLAIMS | 0 | 0 | 0 | 0 | 4 | 14 | 31 | 28 | 65 | 95 | 82 | 91 | 66 | 476 |
| TOTAL CLAIMS | 0 | 0 | 0 | 0 | 4 | 14 | 31 | 30 | 65 | 102 | 96 | 113 | 171 | 626 |
| LOSS RATIO | ERR | ERR | ERR | 0.00% | 293.36% | 160.17% | 67.32% | 50.68% | 78.99% | 175.74% | 123.30% | 81.22% | 96.54% | 101.95% |

Exh 4
SENATE JUDICIARY
EXHIBIT NO. 4
DATE 4-5-89
BILL NO. HB 699

PCFs

Business Development
**RESEARCH & ANALYSIS**

THE DOCTORS' MANAGEMENT COMPANY

## Memorandum

SENATE JUDICIARY
EXHIBIT NO. 4 pg 2
DATE 4-5-89
BILL NO. HB699

To: Judy MacKay

From: Dale Craig

Subject: JUA/PCF Status

Date: August 22, 1988

I am responding to your memo of August 15, 1988 regarding Leonard Kaufman's need for information on PCF and/or JUA status in certain states.

PATIENT COMPENSATION FUNDS

My report of May 24, 1988 gives the Surcharges and Financial Stability of Patient Compensation Funds in Indiana, Kansas, Louisiana, Nebraska, Pennsylvania and Wisconsin. The second section on Financial Stability presents Claims Payout and Fund Balance figures for 1986 and 1987. The most arresting of these financial data was the fund deficit in Wisconsin: $112,101,947 in 1987. A comparison of the Claims Payout and Fund Balance figures for the other states is scarcely less comforting; for example, in Louisiana in 1987 Claims Payout was $18,692,774 but the Fund Balance to cover a similar Claims Payout in 1988 was only $24,660,449. It takes pretty simple arithmetic to see where they are headed.

This report of May 24, 1988 is attached.

JOINT UNDERWRITING ASSOCIATIONS

A number of periodicals reported in early 1988 that JUA's in Florida, Kansas, Pennsylvania, Texas and Wisconsin were solvent; but that JUA's in Massachusetts, New Hampshire, New York, Rhode Island and South Carolina were insolvent. These articles were drawing upon 1986 FINANCIAL CONDITION OF MEDICAL MALPRACTICE JUAs, prepared by Roger K. Kenney of the Alliance of American Insurers for the National Coordinating Committee on Medical Malpractice JUAs. This publication is a very valuable piece of work, and it is attached. The Conclusion at the end of each state section gives a quick summary of the status of each JUA.

I did special work on the Massachusetts JUA which is summarized in my memo to you of April 20, 1988. This reported that "The deficit in Massachusetts could be as high as $800,000,000 or as low as $400,000,000, depending on how it is figured. There has been no private market in Massachusetts since 1975. No companies want to come into that state because of the inadequacy of rates, and because if they are admitted they must be a member of the JUA."

An article (attached) in the Medical Liability Monitor (Vol. 12, No. 4/April 29, 1987, p. 4) stated that "The "massive shortfall - a sum equal to about $17,000 per physician in the state - will have to be shouldered by the medical profession over the next several years."

The information provided here should be adequate for any presentation which has the intent of demonstrating the dangers of establishing Patient Compensation Funds and/or Joint Underwriting Associations, in states which do not already have them.

Attachments:
1. Memo from Dale Craig to Judy MacKay, 5/24/88.
2. 1986 FINANCIAL CONDITION OF MEDICAL MALPRACTICE JUAs
3. "Every Doctor in Massachusetts Could Be On Hook for Huge JUA Shortfall" (MLM)

juapcf1

SENATE JUDICIARY
EXHIBIT NO. 4 pg 4
DATE 4-5-89
BILL NO. HB 699

# R E P O R T

To: Judy MacKay

From: Dale Craig Dale

Subject: Surcharges and Financial Stability of Patient Compensation Funds

Date: May 24, 1988

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## SURCHARGES

INDIANA

125% (1/1/87), applying to insurer's prior acts premium with $100,000/$300,000 limits. 1986 surcharge: 100%. PCF limit: $500,000. Not compulsory but advantageous. ERP is obtainable with surcharge of 125%.

KANSAS

105% (7/1/88), applying to insurer's premium with $200,000/$600,000 limits. 1987/88 surcharge: 90%. PCF limits: $1,000,000/$3,000,000. ERP is automatically provided at no additional cost.

LOUISIANA

Flat charge averaging 49% of insurer's premium with $100,000/$300,000 limits. Not compulsory but advantageous. PCF limit: $500,000. ERP is obtainable with surcharge of 30%.

NEBRASKA

45% (1/1/88), applying to insurer's premium with $200,000/$600,000 limits. 1987 surcharge: 50%. PCF limit: $1,000,000. Not compulsory but advantageous. ERP is obtainable with surcharge of 45%.

PENNSYLVANIA

61%, applying to insurer's premium with $200,000/$600,000 limits (1/1/88; 87% in 1986-87). PCF limits: $1,000,000/$3,000,000. ERP surcharge is the same. Surcharge is based on premium levels of primary carriers.

WISCONSIN

Flat rates: Class 1: 2094 Class 2: 4188
Class 3: 10470 Class 4: 12564

Class 1 = TDC Class 1; Class 2 = TDC Classes 2,3,4;
Class 3 = TDC Classes 5,6; Class 4 = TDC Classes 7,8,9

These apply to primary insurer's premium with $200,000/$600,000 limits (to 7/1/87: from 7/1/87, $300,000/$900,000 limits; after 7/1/88, $400,000/$1,000,000 limits). PCF limit: $1,500,000. No ERP is necessary: the PCF writes occurrence coverage.

FINANCIAL STABILITY

INDIANA

Informant: Diana Pitcher.

Claims payout 1975-12/31/87: $113,753,581.
1986: $26,563,666 1987: $30,781,700

Fund balance 12/31/87: $9,427,645

(The balance was less in 1986.)

KANSAS

Informant: Bob Hayes Name of Fund: Health Care Stabilization

Expenses total 7/1/76 - 12/31/87 $72,875,749

Claims payout same period $53,083,863

Fund balance 12/31/87 $46,568,760

Operating cash 12/31/87 $1,143,043

Remainder invested 12/31/87 $45,425,716

Since 1984, the Commissioner has been urged to keep the Fund on an actuarially sound basis. Predictions have been on target, but the HCSF is still not fully funded. The Balance in 1984 was about seven million, on a pay-as-you-go basis. In five years they expect to be fully funded.

LOUISIANA

Informant: Cheryl Jackson

| | | |
|---|---|---|
| Claims payout | 7/1/87 to date: | $18,692,774 |
| | (This is their annual figure, because they are two payouts per year, in July and January.) | |
| Fund balance | 4/30/88 | $24,660,449 |
| | Actuaries are now considering whether rates are adequate; there are studies each year. | |

NEBRASKA

| | | |
|---|---|---|
| Informant: | Mike Ward | |
| Claims payout | 12/31/87 | $953,875 |
| | 12/31/86 | $1,840,844 |
| | 12/31/85 | $1,030,787 |
| Balance | 12/31/87 | $15,328,941 |
| | 12/31/86 | $10,337,075 |
| | 12/31/85 | $7,843,579 |

PENNSYLVANIA

| | | |
|---|---|---|
| Informant: | Ken Butler | Name of Fund: Catastrophe Loss |
| Claims payout in | 1987: | $136,000,000 |
| | 1986: | $136,000,000 |
| | (I asked him to repeat these identical figures. Probably he was just estimating.) | |
| Balance | 1987: | $70,000,000 |
| | 1986 | $22,500,000 |
| Buffer fund | 12/31/87 | $15,000,000 |
| | The Buffer fund was not needed: the balance has exceeded needs. | |

The Legislature reimburses claims. Projections are made monthly. The surcharge has to recover the above $136 million. Claims were up slightly this year. No emergency surcharge will be needed this year, but it is a possible act, having already been legislated. They don't expect any emergency surcharge over the next four years.

WISCONSIN

| | | |
|---|---|---|
| Informant: | Tom Raykers | |
| Claims payout | 6/30/87: | $16,778,242 |
| | 6/30/86: | $9,413,727 |
| Balance 1987 | FUND DEFICIT | -$112,101,947 |
| 1986 | FUND DEFICIT | -$100,555,257 |

This deficit is because their plan is based on the idea that claims will decline in number!

Investment $73,235,000

This will not cover the deficit.
"A problem the legislature will have to face."

SUMMARY

I will allow the figures for each PCF to speak for themselves. There are many variables to consider when attempting to assess the relative financial stability of these Funds; what I have tried to do here is present the elements which could serve as the basis of an analysis.

pcf2

SURVEY FINDS WASHINGTON STATE'S OBS NOT WILLING TO TOLERATE PREMIUM RISE

About half of those practicing obstetrics in Washington state predict they will stop delivering babies if their malpractice premiums climb any higher, according to a survey by the Washington Academy of Family Practice.

The 419 respondents currently practicing obstetrics were asked to predict how a rise in malpractice premiums would affect their practices and about 50% said they would stop offering their specialty if their insurance payments went over $12,000. Most respondents said they were willing to tolerate premium levels of $8,000 per year, but virtually none were willing to continue obstetrics if premiums rose to $32,000, the researchers found.

Some 29% of all respondents to the questionnaire of 685 physicians reported they had stopped practicing obstetrics during the past five years and an additional 18% of those surveyed reported a decrease in obstetric volume during the same period. About half of those who stopped or decreased their obstetric practice cited professional liability issues as the primary cause.

EVERY DOCTOR IN MASSACHUSETTS COULD BE ON HOOK FOR HUGE JUA SHORTFALL

According to conservative estimates, the Massachusetts Medical Malpractice Joint Underwriting Association (JUA) could be under-reserved by as much as a quarter of a billion dollars. Apparently, the massive shortfall—a sum equal to about $17,000 per physician in the state—will have to be shouldered by the medical profession over the next several years. Already a state insurance department ruling, made early in March, has set the stage for medmal premium increases ranging from $1,500 to $10,600, depending on specialty, effective July 1, 1987. This represents a 23.6% retroactive rate hike for 1985-86, 8.7% for the current fiscal year, and 6.5% for the new fiscal year beginning July 1. The JUA is appealing, on grounds the increases are inadequate. It had requested average rate increases of 65% for 1985-86, 10.9% for 1986-87 and 8.1% for 1987-88.

JUA Executive Director Richard Moore explained that the huge JUA deficiency involves two operational periods--from the JUA's inception in 1975 through 1982, and policy years 1983 through 1986. The early period involves an estimated shortfall of $140 million, not including loss adjustment expenses and unreported claims (IBNR). In addition, "deferred premium liabilities" for the past three years are estimated at $110 million. Moore said the statutory deficit was $600 million but lower if discounted by projected income.

The JUA's enabling statute provided that if the initial premium rates proved inadequate, the JUA could petition for "deferred premiums" to bolster the reserves. "We have exhausted all premium and investment income for the 1975-82 period and have petitioned the State Insurance Department for relief," Moore told MLM. Those hearings are scheduled in the fall.

Some observers believe the statute relating to the early years of operation encumbers all practicing physicians in the state, whether or not they were ever members of the JUA. The "all physician concept" is expected to be challenged in court by self-insured programs in Massachusetts.

The "deferred liability premium charge" relates exclusively to loss experience over the last three years and involves only JUA members. During this period requested rate increases were delayed by the regulatory process, Moore said. Anticipating this possibility, the state legislature installed the "deferred premium" provision. If subsequent hearings establish that prior year rates before 1983 were inadequate, the JUA can collect the difference between what was charged and the rate ultimately approved by the State Insurance Department.

In the meantime, the recent insurance department ruling provides that doctors shall pay off $110 million in deferred premium increases for years 1983-87 over a five-year period with an annual 11% interest rate. Doctors are seeking bigger fee increases fromBlue Cross/Blue Shield to pass through some of the extra premium costs to patients, a legislatively authorized procedure. The insurance department is calculating possible financial impact of that state's new medmal law to set appropriate rates. (See MLM, Sept., 1986)

SENATE JUDICIARY
EXHIBIT NO. 4 DQ9
DATE 4-5-89
BILL NO. HB 699

MEMORANDUM

To: Judy MacKay

From: Dale Craig

Subject: Massachusetts JUA

Date: April 20, 1988

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In response to your memo of April 14, I have studied the Massachusetts Code and the 1986 Financial Condition of Medical Malpractice JUAs. I also spoke with Jerry Cassidy of the Massachusetts Department of Insurance. I shall answer your questions in the order you put them.

1. Status of the Mass. JUA: The deficit is as high as $800,000,000 or as low as $400,000,000, depending on how it is figured. There has been no private market in Mass. since 1975. No companies want to come into that state because of the inadequacy of rates, and because if they are admitted they must be a member of the JUA. It is certainly not advisable for TDC to consider entering at this time.

2. If we are not licensed in Mass., we are not responsible for JUA debts and we would not have to pay an assessment when leaving the state, since only licensed companies are required to be in the JUA. Therefore being the non-domiciled insurer of a purchasing group is more attractive than being admitted. We shall have to find out whether we can depend on operating without obtaining Surplus Lines Approval, however.

3. Rate levels are set by the Insurance Department, however, for foreign insurers as well as admitted. TDC cannot write for more than the rates established by the JUA for each specialty. If we want to write for less, we may need Department approval. The Department has a "Fix and Establish" rule just as other states have "Use and File," etc., and this is unique to Massachusetts. TDC must use rates set by the Department and report any deviations, which will be examined for consistency and fairness.

4. If we want expert advice about the Massachusetts laws applying to insurance, these are legal firms in Boston who know insurance law and the JUA:

Morrison, Mahoney and Miller
Contact: Steve Parys, Esq.

Palmer and Dodge
Contact: Mike Callaghan, Esq.

cc: Manuel S. Puebla
John J. Kenny, Jr.

massachu1

HOWARD H. LAMB
PRESIDENT

# THE DOCTORS MANAGEMENT COMPANY

SENATE JUDICIARY
EXHIBIT NO. 4 pg 10
DATE 4-5-89
BILL NO. HB1099

January 28, 1989

Dear :

As the endorsed professional liability carrier for the Montana Medical Association, The Doctors' Company places great value in our ongoing relationship, as we have demonstrated through the significant discount offered to your membership, the administrative fees paid directly to the MMA. Our sponsorship of many programs and activities at your request and through strong membership and risk management services.

We have been quite frustrated in the past several months with what appears to be a failure to inform us of key decisions and legislative developments which would have significant impact upon the coverage we provide your membership. This has certainly been the case with respect to the development of the Assured Compensation Fund proposal and the decision to require members of the MMA to also belong to the AMA.

We are hopeful that through the recent intervention of MMA President Mike Sadaj, this lapse of communication is on its way to being resolved, for which we are grateful.

A by-product of our recent discussion with Dr. Sadaj and Mr. Zins is that we finally received the final version of the "Montana Assured Compensation Fund" proposal two weeks ago along with the actuarial study prepared by Milliman and Robertson at your request. We received the updated actuarial study by that same firm last week.

While we understand that the proposal and the actuarial study may be modified again to reflect amendments that have been suggested in a recent subcommittee hearing by your legislative author, we were able, upon the receipt of the material provided, to finally prepare our own actuarial analysis of the "Montana Assured Compensation Fund" proposal, a copy of which is enclosed with this letter.

401 WILSHIRE BOULEVARD
SANTA MONICA, CA 90401
(213) 451-3011
A WHOLLY-OWNED
SUBSIDIARY OF
THE DOCTORS COMPANY

We want to hasten to say that up to this point we have avoided commenting on the proposal since it was undergoing numerous changes in its development stage and because we were cautious about influencing the work of your consultant and interested parties with data that might be seen as contradictory or not congruent to your intent.

In brief, we have been studiously neutral about the proposal to all who asked our opinion, and have provided your consultant and your actuary with every piece of information that he has requested of us.

It is unfortunate that we must inform you that we have discovered that your consultant's plan fails to include 100% of the fixed expenses in the primary (100/300) layer of coverage which fundamentally affects his supposition of the amount that the Montana Patient Assured Compensation Fund will save Montana doctors on their malpractice insurance premiums. Please see Point #2 of the accompanying actuarial analysis.

The Fund's rates also fails to take into account the administrative costs of running the Fund, which are indicated to be $100,000 (a most conservative amount, in our opinion). Please see page five of the enclosed actuarial analysis.

Another actuarial factor utilized by actuarial consultant, Mr. Bickerstaff, with which we disagree, is the pure premium for the mature claims made policy expressed in relationship to the pure premium for occurrence policies. Mr. Bickerstaff suggests using 75.7% and 77.3% while we would argue for a more prudent 85%. Actuaries can certainly disagree on this point, but you should know that Mr. Bickerstaff recommended a factor for this variable of 95% to the Illinois State Medical Insurance Exchange for their recent filing with the State of Illinois. Please see Point #7 of the enclosed actuarial analysis.

The result of these unfortunate misstatements, missassumptions and omissions, according to our enclosed actuarial analysis is that the Fund will save FP's and OB's much less money than your consultant has claimed. In fact, the savings amount to 5.2% for FP/OB and 1.8% for OB respectively, not the 19.8% and 16.3% savings called out in your consultant's report over five years under the Fund plan.

We also had our actuary look at the impact of tail coverage on the potential savings of the Fund. It our company chose not to administer the Fund and provide excess layer coverage, but instead chose to cease writing coverage in the state, the cost of tail coverage would wipe out any savings expected in creating the Fund and would in fact, cost Montana physicians 1.3% more than present rates for coverage over a five year period according to our analysis. Please see Point #8 of the enclosed actuarial analysis.

Next we want to comment on the solvency issue of the Fund. Although Mr. Bickerstaff thinks that the Fund only has 1% probability to run out of money after five years if it increases the rates 14% every year during the next five years. However, our view on the solvency of the Fund is not as optimistic as Mr. Bickerstaff's. Traditionally the net written premium to surplus ratio and the reserve to surplus ratio can not exceed 3 to 1 and 4 to 1 respectively. If the Fund fails to meet these requirements, it could be declared financially impaired or insolvent by the Insurance Department and put into receivership before it completely runs out of money. Based on the way Mr. Bickerstaff calculates the required capitalization and its small amount, we feel that the chance of insolvency for the Fund is much greater than 1%. We want to emphasize that the solvency issue should not be dealt with lightly when you consider the well being of your members and the claimants.

While the impact of loss control and risk management are less quantifiable than the matters raised above, we think you should carefully consider whether any manager of a Fund would exercise the same diligence and prudence necessary in managing claims in the primary layer of coverage where losses would be paid for by the Fund as they would if it were their own money at risk.

A final point of analysis that we think is worthy of your consideration is that, unlike The Doctors' Company, the Fund does not pay dividends and can assess its insureds for unexpected losses, should they occur.

We wish that we could have provided this information to you sooner than this, and would have done so if the underlying assumptions had been known to us sooner.

We offer this analysis to you at this time in the strictest confidence in the hope that you will see fit to withdraw or suspend your legislative proposal while you consider these startling new facts. We would be pleased to work with you to test other assumptions and methodologies, if you wish to have us do so.

You must understand that while we have avoided, and continue to avoid public comment on the Fund proposal for the moment, we are under increasing pressure from our insureds and from elected officials, who are scheduling hearings on the Fund legislation in the immediate future, to provide our insights into this plan. We have been told that we will be called to testify at such hearings and we feel compelled to comply if such an invitation is issued.

We offer all of the above with the hope that you will see our position and the fact that we have transmitted it in confidence to you for your action, as an act of loyalty and friendship. We hope that you agree that our mutual responsibility to the dedicated physicians of Montana will be well served by consideration of our findings and steps you take to deal with the problems we have discovered.



Best regards,

Howard H. Lamb

HHL/jc

Enclosures

# ANALYSIS OF MMA PROPOSAL IN MONTANA

At Mr. Lamb's request, I analyzed the proposal of the Montana Patient Compensation Fund (PCF) for FP/OB and OB/GYN. The following are the results of my analysis and my comments on Bickerstaff's PCF study:

1. PCF's Savings

I do not see any apparent reasons that the establishment of PCF will reduce the total amount of indemnity. The savings in total premiums can only be attributed to the reductions in premium taxes and commissions on the excess portion of the total premiums.

Let P = 100/300 limit pure premium

F = fixed expenses not varying with policy limit

v = variable expense ratio

t = 1M/3M rate without PCF

u = 1M/3M rate with PCF, excluding PCF's administrative expenses.

f = F/t

i = increased limit factor for 1M/3M using 100/300 as a base.

Then

$$t = \frac{i\,P + F}{1 - v}$$

$$u = \frac{P + F}{1 - v} + (i - 1)\,P$$

Thus the savings with PCF is equal to:

$$1 - \frac{u}{t} = 1 - \frac{1-v-f + i \times f + (i-1)\,(1-v)\,(1-v-f)}{i\,(1-v)}$$

2. Adjustment of 100/300 Rates

Since PCF will not reimburse us for our fixed expenses as proposed by MMA, we need to recoup our fixed expenses in the 100/300 rates.

Let $b$ = 100/300 rate in MMA proposal

$c$ = 100/300 rate including 100% of fixed expenses

$P$, $F$, $v$, $t$, $f$, $i$ be defined in 1.

Then

$$b = \frac{t}{i} = \frac{P + F\left(\frac{b}{t}\right)}{1 - v} \Rightarrow b = \frac{P}{1 - v - f}$$

$$c = \frac{P + F}{1 - v} \Rightarrow c = \frac{[1 - v + f\ (i - 1)]}{(1 - v - f)\ (1 - v)}$$

Thus the 100/300 rate in the MMA proposal should be increased by:

$$\frac{c}{b} - 1 = \frac{f\ (i - 1)}{1 - v}$$

3. Relationship between 100/300 rate and rate for pool coverage with PCF in place:

Let $e = (i - 1)\ P$ = rate for pool coverage

$c$, $P$, $v$, $i$, $f$ be defined in 1 and 2.

Then $$\frac{e}{c} = \frac{(i - 1)\ (1 - v - f)\ (1 - v)}{1 - v + f\ (i - 1)}$$

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4. Based on our Montana review done by Mike Ward in October, 1988, we concluded that our rates for FP/OB and OB/GYN are very reasonable. The PCF's proposal used 2.00 as the increased limit factor for 1M/3M. In order to make our premium calculations compatible with the proposal for PCF, I also used 2.00 as the increased limit factor for 1M/3M to calculate the premiums which I believe should be charged. The following are my estimated premiums by using our current rates and expense ratios where v = 0.122 and f = 0.150 for FP/OB and OB/GYN after the 18% group discount:

FP/OB

| Year | Primary Coverage | Pool Coverage | Total Coverage With Pool | Total Coverage Without Pool | $ Savings With Pool | % Savings With Pool |
|---|---|---|---|---|---|---|
| 1st | $12,225 | $ 7,604 | $ 19,829 | $ 20,880 | $1,051 | 5.0% |
| 2nd | 13,937 | 8,669 | 22,606 | 23,803 | 1,197 | 5.0 |
| 3rd | 15,888 | 9,882 | 25,770 | 27,136 | 1,366 | 5.0 |
| 4th | 18,112 | 11,266 | 29,378 | 30,925 | 1,557 | 5.0 |
| 5th | 20,648 | 12,843 | 33,491 | 35,265 | 1,774 | 5.0 |
| Total | $80,810 | $50,264 | $131,074 | $138,019 | $6,945 | 5.0 |

OB/GYN

| Year | Primary Coverage | Pool Coverage | Total Coverage With Pool | Total Coverage Without Pool | $ Savings With Pool | % Savings With Pool |
|---|---|---|---|---|---|---|
| 1st | $ 22,858 | $14,218 | $ 37,076 | $ 39,039 | $ 1,963 | 5.0% |
| 2nd | 26,058 | 16,208 | 42,266 | 44,504 | 2,238 | 5.0 |
| 3rd | 29,706 | 18,477 | 48,183 | 50,735 | 2,552 | 5.0 |
| 4th | 33,865 | 21,064 | 54,929 | 57,838 | 2,909 | 5.0 |
| 5th | 38,607 | 24,014 | 62,621 | 65,935 | 3,314 | 5.0 |
| Total | $151,094 | $93,981 | $245,075 | $258,051 | $12,976 | 5.0 |

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The total premiums with pool do not include the administrative cost of the pool. If we include the administrative cost of the pool, then the savings will be less than those shown in the above tables. Please note that I did not include a 15% contingency margin in the rates for pool coverage.

5. The following tables show the premium comparisons with and without PCF as published in the proposal of PCF assuming that TDC will provide the primary coverage:

FP/OB

| Year | Primary Coverage | Pool Coverage | Total Coverage With Pool | Total Coverage Without Pool | $ Savings With Pool | % Savings With Pool |
|---|---|---|---|---|---|---|
| 1st | $10,440 | $ 6,313 | $ 16,753 | $ 20,880 | $ 4,127 | 19.8% |
| 2nd | 11,902 | 7,197 | 19,098 | 23,803 | 4,705 | 19.8 |
| 3rd | 13,568 | 8,204 | 21,772 | 27,136 | 5,363 | 19.8 |
| 4th | 15,467 | 9,353 | 24,820 | 30,935 | 6,114 | 19.8 |
| 5th | 17,633 | 10,662 | 28,295 | 35,265 | 6,970 | 19.8 |
| Total | $69,009 | $41,730 | $110,738 | $138,019 | $27,279 | 19.8 |

FP/OB

| Year | Primary Coverage | Pool Coverage | Total Coverage With Pool | Total Coverage Without Pool | $ Savings With Pool | % Savings With Pool |
|---|---|---|---|---|---|---|
| 1st | $ 19,520 | $13,141 | $ 32,661 | $ 39,039 | $ 6,378 | 16.3% |
| 2nd | 22,253 | 14,981 | 37,234 | 44,504 | 7,271 | 16.3 |
| 3rd | 25,368 | 17,078 | 42,446 | 50,735 | 8,289 | 16.3 |
| 4th | 28,920 | 19,469 | 48,389 | 57,838 | 9,449 | 16.3 |
| 5th | 32,969 | 22,195 | 55,163 | 65,935 | 10,772 | 16.3 |
| Total | $129,029 | $86,863 | $215,893 | $258,051 | $42,159 | 16.3 |

The above tables do not include the rate adjustment for the primary coverage as discussed in 2. They also do not include the administrative cost of the pool; where the fixed cost for FP/OB is $490 and the fixed cost for OB/GYN is $1,020 in the first year as indicated in Bickerstaff's study.

6. Had MMA adjusted the rates for the primary coverage and included the administrative cost of the pool, the premium comparisons in the MMA proposal would look like the following:

FP/OB

| Year | Primary Coverage | Total Coverage: Pool Coverage | With Pool | Without Pool | $ Savings With Pool | % Savings With Pool |
|---|---|---|---|---|---|---|
| 1st | $12,225 | $ 6,803 | $ 19,028 | $ 20,880 | $ 1,852 | 8.9% |
| 2nd | 13,937 | 7,755 | 21,692 | 23,803 | 2,111 | 8.9 |
| 3rd | 15,888 | 8,841 | 24,729 | 27,136 | 2,407 | 8.9 |
| 4th | 18,112 | 10,079 | 28,191 | 30,935 | 2,744 | 8.9 |
| 5th | 20,648 | 11,490 | 32,138 | 35,265 | 3,127 | 8.9 |
| Total | $80,810 | $44,968 | $125,778 | $138,019 | $12,241 | 8.9 |

OB/GYN

| Year | Primary Coverage | Total Coverage: Pool Coverage | With Pool | Without Pool | $ Savings With Pool | % Savings With Pool |
|---|---|---|---|---|---|---|
| 1st | $22,858 | $14,161 | $ 37,019 | $ 39,039 | $ 2,020 | 5.2% |
| 2nd | 26,058 | 16,144 | 42,202 | 44,504 | 2,302 | 5.2 |
| 3rd | 29,706 | 18,404 | 48,110 | 50,735 | 2,625 | 5.2 |
| 4th | 33,865 | 20,980 | 54,845 | 57,838 | 2,993 | 5.2 |
| 5th | 38,607 | 23,917 | 62,524 | 65,935 | 3,411 | 5.2 |
| Total | $151,094 | $93,606 | $244,700 | $258,051 | $13,351 | 5.2 |

Thus, the probable savings would only be 8.9% for FP/OB and 5.2% for OB/GYN not 19.8% and 16.3% as claimed by the MMA proposal.

7. Bickerstaff assumes that the pure premiums for the mature claims-made policy are 75.7% and 77.3% of the pure premiums for the occurrence policy for FP/OB and OB/GYN, respectively. Although those factors are calculable from the trend, report pattern and payment pattern assumptions, but I still think it is prudent, given the uncertainty of the real world, to use some factors higher than those recommended by Bickerstaff. Based on what I have seen in other companies' filings and discussion with Mike Ward, I will pick 85% as a reasonable number to use. Just for your information, Bickerstaff recommended Illinois State Medical Insuance Exchange to use 95% in their latest filing. The following tables show the premium comparisons by assuming that the pure premium for the mature claims-made policy is 85% of the pure premiums for the occurrence policy and the rates for the pool coverage also include the adminstrative cost of the pool:

FP/OB

| Year | Primary Coverage | Pool Coverage | Total Coverage With Pool | Total Coverage Without Pool | $ Savings With Pool | % Savings With Pool |
|---|---|---|---|---|---|---|
| 1st | $12,225 | $ 7,574 | $ 19,799 | $ 20,880 | $ 1,081 | 5.2% |
| 2nd | 13,937 | 8,634 | 22,571 | 23,803 | 1,232 | 5.2 |
| 3rd | 15,888 | 9,843 | 25,731 | 27,136 | 1,405 | 5.2 |
| 4th | 18,112 | 11,221 | 29,333 | 30,935 | 1,602 | 5.2 |
| 5th | 20,648 | 12,792 | 33,440 | 35,265 | 1,825 | 5.2 |
| Total | $80,810 | $50,064 | $130,874 | $138,019 | $ 7,145 | 5.2 |

OB/GYN

| Year | Primary Coverage | Pool Coverage | Total Coverage With Pool | Total Coverage Without Pool | $ Savings With Pool | % Savings With Pool |
|---|---|---|---|---|---|---|
| 1st | $ 22,858 | $ 15,468 | $ 38,326 | $ 39,039 | $ 713 | 1.8% |
| 2nd | 26,058 | 17,634 | 43,692 | 44,504 | 812 | 1.8 |
| 3rd | 29,706 | 20,102 | 49,808 | 50,735 | 927 | 1.8 |
| 4th | 33,865 | 22,917 | 56,782 | 57,838 | 1,056 | 1.8 |
| 5th | 38,607 | 26,125 | 64,732 | 65,935 | 1,203 | 1.8 |
| Total | $151,094 | $102,246 | $253,340 | $258,051 | $ 4,711 | 1.8 |

In this case, we can see that the potential savings has greatly reduced and it is probably not worth the effort to set up the PCF anymore.

8. If The Doctors' Company decides to pull out from Montana, then our insured doctors have to either purchase a tail coverage from us or purchase a coverage which covers prior acts from another carrier. If no carriers sell coverage which covers prior acts, then our insured doctors have to purchase a tail coverage from us. The additional cost of the tail coverage is so high which will not only wipe out the potential savings claimed in the MMA proposal but also cost the doctors more money to insure after PCF is established. The following is an example. If UMIA is the only company which still writes in Montana after PCF is in place. Since UMIA does not cover prior acts for OB/GYN, our insured OB/GYN doctors have to purchase a tail coverage from us. The premiums for the OB/GYN doctors will then look like the following:

SENATE JUDICIARY
EXHIBIT NO. 4 Pg 21
DATE 4-5-89
BILL NO. HB 699



OB/GYN

Total Coverage

| Year | Primary Coverage | Pool Coverage | Tail Coverage | Total Coverage With Pool | Coverage Without Pool | $ Savings With Pool | % Saving With Pool |
|---|---|---|---|---|---|---|---|
| 1st | $ 6,609 | $ 4,248 | $70,270 | $ 81,127 | $39,039 | $-42,088 | -107.8 |
| 2nd | 16,324 | 10,494 | 0 | 26,818 | 44,504 | 17,686 | 39.7 |
| 3rd | 25,194 | 16,196 | 0 | 41,390 | 50,735 | 9,345 | 18.4 |
| 4th | 31,006 | 19,931 | 0 | 50,937 | 57,838 | 6,901 | 11.9 |
| 5th | 37,208 | 23,917 | 0 | 61,125 | 65,935 | 4,810 | 7.3 |
| Total | $116,341 | $93,606 | $70,270 | $261,397 | $258,051 | $- 3,346 | - 1.3 |

In the above table, I assume (1) the five year maturation schedule is 0.3, 0.65, 0.88, 0.95 and 1.00 and 100/300 limit premium contains 100% of the fixed expenses for UMIA; (2) our OB/GYN doctors will still insure with TDC if PCF is not established; (3) TDC will not provide free tail coverage; and (4) PCF's maturation schedule is the same as UMIA's.

Finally, I want to say that using UMIA's rates in this table is for comparison purposes only and we do not either agree or disagree on their rates.

SENATE JUDICIARY
EXHIBT NO. 4 ATT 22
DATE 4-5-89
BILL NO. HB 699

MONTANA MEDICAL ASSOCIATION

2021 Eleventh Avenue • Helena, Montana 59601-4890
Telephone (406)443-4000 or In-State 1-800-MMA-WATS (662-9287)
FAX (406)443-4042

March 22, 1989
Wednesday

MAR 24 1989
PRESIDENT TDMC

Mr. Howard H. Lamb
President
The Doctors' Management Company
401 Wilshire Blvd.
Santa Monica, California 90401

Dear Mr. Lamb:

On behalf of the MMA Executive Committee, thank you for your letter, received March 1, 1989. Even though our response is contained below, we of course wish it had been provided well prior to the start of the legislative session, as the data you used and the bill language reviewed was that of late November, 1988.

Our actuary, consulting attorney, and Executive Committee have reviewed the contents of your letter and attachment at length over the last few weeks and they believe that the project is sound, even though we understand you feel your rates are appropriate. It is important we keep in mind that the problem with which we are all concerned is the loss of obstetrical services, especially in rural Montana.

Some of your claims and conclusions warrant further exploration because they involve complex subjects and because of a lack of direct information contained in your letter. Hence we ask the following questions in the spirit of properly solving this pressing problem:

QUESTION 1: If you believe the enterprise is undercapitalized, what are your conclusions and the underlying data as to the amount of capital required for the following levels of participation: (a) 100 FPs/50 OBGYNs; (b) 70 FPs/30 OBGYNs?

QUESTION 2: If you believe that ~~$100,000~~ is an inadequate administrative annual charge, ~~what are~~ your conclusions and the underlying data as to the administrative amount required, by type of expenditure and phase of the program, so that your conclusion can be properly analyzed?

SENATE JUDICIARY
EXHIBIT NO. 4 Pg 23
DATE 4-5-89
BILL NO. HB 609



QUESTION 3: Is it correct that your loss cost or actual dollars which need to be paid out on claims, apart from any administrative load, for a $100,000/$300,000 policy with your company is for approximately $7,604 for a family practitioner doing obstetrics, and if not, what is that loss cost? Similarly, is it $14,218 for obstetricians/gynecologists, and if not, what is that loss cost?

QUESTION 4: If you believe that a proper test of solvency is that the net written premium to surplus ratio cannot or should not exceed 3 to 1, do you agree that this ratio for the Patient Compensation Fund is: (a) as indicated by the actuary's letter of March 2, 1989, well below that maximum benchmark; (b) below the same ratio for most, if not all, all liability and casualty carriers writing in Montana?

QUESTION 5: If your Company left the market in Montana and a doctor wished to purchase an extended reporting endorsement on $100,000/$300,000 or his or her exposure, what is the 1989 cost of such a "tail" policy? Would you agree that it is not the $70,000 postulated in your recent letter and that the legislation provides for the fund, at Section 23, to provide prior acts coverage for the amounts over $100,000 up to $1 Million?

QUESTION 6: Your letter concludes that the legislation can, unlike with your carrier, assess physicians for unexpected losses above and beyond the annual charge. Would you agree that the legislation provides at Section 7(2), that except for the annual charges in that section, participating physicians are not subject to assessment, and that that circumstance is identical to that of The Doctors' Company?

QUESTION 7: You make reference to the actuary for the MMA not having included in the recommended rates the amount of administrative costs of running the pool. Do you agree that at page 7 of the actuarial report and on Exhibit 4-1, page 1 of the same report, that such an administrative load is contemplated and then included in the gross rates?

Please advise us of your responses to the above questions and any others you might have so that we can make sure that the legislation is of the best quality.

Sincerely,

G. Brian Zins
Executive Vice President

cc: MMA Executive Committee
Richard C. Nelson, M.D.
John W. McMahon, M.D.

EDWARD H. LAMB
PRESIDENT

THE DOCTORS MANAGEMENT COMPANY

SENATE JUDICIARY
EXHIBIT NO. 4 DD 24
DATE 4-5-89
BILL NO. HB 699

March 30, 1989

Mr. Brian G. Zins
Montana Medical Association
2021 Eleventh Avenue, Suite 12
Helena, Montana 59601

Dear Brian:

I am in receipt of your letter to me of March 22, 1989, which responds in part to my confidential letter to you of late February regarding the legislative proposal title "The Assured Patient Compensation Fund".

As you will recall, I submitted, with my letter a detailed actuarial study which demonstrated why we believe that the "Fund" proposal is not workable and could create serious dangers for those of your membership who chose to join such a plan.

I had been deeply disappointed by the response of the MMA leadership to my letter prior to receiving your communication. Except for two telephone calls from your President, Mike Sadaj, M.D. and another member of the Executive Committee, I have received no communication realtive to our comments. In the case of those two contact, I reiterated that we offered our analysis in the spirit of friendship, in the hope that you would retire this seriously flawed proposal from consideration in light of the facts and meet with us to create a workable solution.

With respect to your letter, which you state is based on your lengthy review as well as that of your consultant states that you continue to believe that the "Fund" proposal is sound, but asks that we respond to a number of questions related to our findings that the "Fund" proposal is unworkable as written. We are pleased to respond to your questions below. With respect to question #1 our actuary has analyzed your question based upon the following accepted assumptions, which I am sure that your own actuary will concur in and which we provide with the understanding that neither you nor I are actuaries, but in the hope that the detail provided will help to convince you of the facts.

401 WILSHIRE BOULEVARD
SANTA MONICA, CA 90401
(213) 451-3011

The assumptions are as follows:

1. Let
   - C = initial capital
   - C = capital at the end of year
   - P = net earned premium in year
   - W = net written premiums in year
   - I = investment income in year
   - E = underwriting expenses in year
   - L = incurred losses in year
   - m = minimum capital required by Montana

$C_{+1} = C = P_{+1} + I_{+1} - E_{+1} - L_{+1}$

If we use the 3 to 1 ratio as a rule to determine the required capital, then:

P {PCF will not meet the 3 to 1 requirement in the next 5 years}
=P {C < max (1/3 w ,m)}
+P {C > max (C 1/3 w ,m),C < max (1/3 w ,m)}
+P {C >max (1/3 w , m), C > max (1/3 w , m), C < max (1/3 w ,m)}
+P {C > max (1.3 w ,m), C > max (1/3 w ,m), C > max (1/3 w ,m), C < max (1/3 w ,m)}
+P {C > max (1/3 w ,m), C > max (1/3 w ,m), C > max (1/3 w ,m), C > max (1/3 w ,m), C < max (1/3 w ,m)}

Based on Mr. Bickerstaff's Monte Carlo simulation, you can determine the C such that the probability that PCF will not meet the 3 to 1 requirement in the next 5 years is less than or equal to 1%.

We believe your initial capital is based on cash flow rather than proper capitalization. We believe that under your initial capital, the plan would run out of capital before it ran out of cash.

Rather than try to suggest the amount of Capital needed under scenario (a) or (b), we would suggest you use the above assumptions and ask your actuary to determine the capital needed. I am sure that you will be forced to agree, however, that it is far in excess of the amount that you have represented to the Legislature as being adequate.

With respect to your question #2, which asked for our input on the costs for administering the "Fund" we offer the following:

Our Claims Department estimates that the administrative cost is likely to be between $200,000 to $250,000. The administrative cost should include salary, supplies,

telephones, office space and other miscellaneous costs. It does not include the actual administration of claims themselves or the underwriting costs associated with the business.

With respect to your question #3, based on our data and our assumptions, the answer to your question is yes.

With respect to your question #4, our response is as follows:

Initially the net written premium to surplus ratio may be below 3 to 1 for the Fund. However, as the time progresses, we think the ratio will deteriorate. Based on Mr. Bickerstaff's Monte Carlo simulation,

> P {The capital of the Fund will be less than or equal to 0 in the next 5 years} = 0.01
>
> Thus it is very easy to conclude that,
>
> P {The capital of the Fund will be less than or equal to 1/3 of the net written premium in the next 5 years} > 0.01

With respect to your question #5, our response is as follows:

The November 1988 version of the bill doesn't provide for the prior act coverage. Thus $70,000 is the premium for the tail coverage from first dollar to $1,000,000/$3,000,000., also Section 23 according to our reading doesn't speak to tail coverage. We would leave it to your actuary to determine the cost of tail coverage at the reduced level, but we would point out that a denegation of a Doctors' existing coverage for the provision of tail might well cost less but would expose that Doctor to much greater liability. Since the "Fund" is uniformly premised upon both a $100,000/$300,000 primary layer and an excess layer, I am troubled to think that the "Fund" would offer substantially diminished coverage for prior acts than it would for current coverage.

With respect to your question #6, our response is as follows:

It is open to interpretation, but our opinion is that if there is not enough funds - then there will be assessments. In fact, the history of such funds throughout the Country, as you undoubtedly have been told, is that such assessments are common and large. In states that have been held out to have successful "Funds" such as Indiana and Kansas, the assessment has been over 100% of the annual premium. Other states, such as Louisiana, Nebraska and Pennsylvania have surcharged Doctors who participate in their "Funds" between 40-60% of the annual premium. Some states, like Wisconsin allow a deficit to accrue without surcharge, viewing that development as a problem the Legislature will have to face.

With respect to your question #7, our response is as follows:

The rates for the pool coverage in the premium comparison included in Mr. Neely's letter to you dated December 5, 1988, do not include the administrative cost for the Fund. A copy of the premium comparison pertaining to The Doctors' Company is attached for your reference.

I would also like to raise a few other points of concern to The Doctors' Company.

It is my understanding that testimony has been given by MMA representatives to a House Sub-Committee that supports the "Fund" using the same insupportable numbers we called to your attention.

I further understand that you have allowed the proposal to be amended to take out the limit on non-economic damages and other cost controls that offered the last slim hope of making the "Fund" workable. Further, and most amazing to me, is my understanding that you have amended the bill to cover all tail exposure and agreed to remove the "Fund's" losses from the State's Guaranty Fund.

It is our estimate that, if all potential participants in the "Fund" were to join, the tail coverage exposure would be at least $8,000,000. Since this is more than the capitalization you are seeking from the State or, alternatively through the surcharge of all Property and Casualty insurers and since the Guaranty Fund will not be available as a safety net, it would seem that the legislation is now developed in a way that virtually assures its bankruptcy with all losses above the capitalizations flowing directly to those doctors to whom the legislation promised relief.

I also understand that your Counsel made a comment in a public hearing, that our Company might leave the State, which is wholly without basis and grossly insulting in light of both our long standing commitment to serve Montana's medical community and our relationship with the MMA in which we provide discounts for your membership and many thousands of dollars in administrative fees to your organization.

I have arrived at the sad conclusion that you intend to press forward with this flawed legislation in spite of the facts that we have presented to you in the past and the new amendments, which clearly make the plan even more untenable I hope that our timely response to your questions will help to persuade you to abandon your current course of action.

Numerous Legislators and MMA members have requested our opinion of the "Fund" proposal. I have held off in commenting, but can do so no longer. The Doctors' Company will oppose this plan, pointing out our specific objections and that they have been your hands for review for some time along with the additional material presented herein as well as other pertinent information.

I would like to ask again that you consider withdrawing the "Fund" proposal and sit down with us to craft a workable solution to the problems of affordability and availability of medical malpractice coverage which we both agree requires immediate attention. I take no pleasure from airing a public disagreement among friends, but without some change in a change in your position I can see no alternatives.

SENATE JUDICIARY
EXHIBIT NO. 4 pg 28
DATE 4-5-89
BILL NO. HB 699

Best regards,

Howard H. Lamb

HHL/jc

cc: J. Michael Sadaj, M.D.
Donald L. Harr, M.D.
Edward P. Bergin, M.D.
John R. Gregory, M.D.
John T. Mollory
John R. Halseth, M.D.
Van Kirke Nelson, M.D.
F. John Allaire, M.D.
Robert M. St. John, M.D.
Peter L. Burleigh, M.D.
Donald E. Engstrom, M.D.
Stuart A. Reynolds, M.D.
Ladd D. Rutherford, M.D.

1989 Montana Rate Comparison TDC vs UMIA
+ TDC rates figured w/ 16% net MMA discount $1/3m liability limits

| Specialty / Class Code | TDC yr 1 | UMIA yr 1 | TDC yr 2 | UMIA yr 2 | TDC yr 3 | UMIA yr 3 | TDC yr 4 | UMIA yr 4 | UMIA yr 5 |
|---|---|---|---|---|---|---|---|---|---|
| Anesthes. 5/5 | 5486 | 6855 | 9450 | 15929 | 12192 | 22184 | 13366. | 24023 | 25249 |
| Card Int Rad 5/2 | 2690. | 7132. | 4248 | 2517. | 5481 | 3471. | 6012. | 3752. | 3939. |
| Card Surg 4/3 | 6731. | 3676 | 10621 | 8480 | 13704 | 11791 | 15026 | 12765 | 13414 |
| Dermatology 1/1 | 1499 | 1132 | 2365 | 2517 | 3054 | 3471 | 3349. | 3752 | 3939. |
| Diag Rad 2a/b (Urst angiograms) | 3218 | 3676 | 5077 | 8480 | 6550. | 11791 | 7183 | 12765 | 13414 |
| ER 4/3 | 6731. | 3676 | 10621. | 8480 | 13704 | 11791 | 15026. | 12765 | 13414 |
| EP min surg 2/2 | 3365 | 2053 | 5310 | 4685 | 6852 | 6499 | 7511 | 7033 | 7389 |
| EP maj surg 4/3 | 6731 | 3676 | 10621 | 8480 | 13704 | 11791 | 15026. | 12765 | 13414 |
| EP w/ OB 6/4A | 9351. | 5589 | 14760 | 12790 | 19044 | 17753 | 20880. | 19272 | 20185 |
| Gen Surg 7/5 | 8377 | 6855 | 13218 | 15929 | 17056 | 22184 | 18699. | 24023 | 25249 |
| Int Med 1a/2 | 2689 | 1132. | 4248 | 2517. | 5481. | 3471. | 6012 | 3752. | 3939 |
| Neurology 2a/2 | 3365 | 2053 | 5310. | 4685 | 6770 | 6499 | 7511. | 7033 | 7389 |
| Neurosurg 9/7a | 17955 | 15125 | 28333 | 35341 | 36556 | 49274 | 40075 | 53322 | 56103 |
| OB/GYN 10/7a | 17490 | 11369 | 27598 | 26546 | 35608 | 37005 | 39039 | 40082 | 42132 |
| Orthopedic 8/2 | 12717 | 11369 | 20270 | 26546 | 25896 | 37005 | 28392 | 40082 | 42132 |
| Otolaryng 4A/5 update | 8603 | 6855 | 13579 | 15929 | 17522 | 22184 | 19211 | 24023 | 25249 |
| Plastic Surg 6/6 | 9351 | 8299 | 14760 | 19338 | 19044 | 26946 | 20880 | 29184 | 30676 |
| Psychiatry 1/1a | 1499 | 1676 | 2365 | 2377 | 3054 | 3370 | 3349 | 3538 | 3714 |
| Urology 4/4 | 6731 | 4768 | 10621 | 11013 | 13704 | 15320 | 15026 | 16587 | 17431 |
| Podiatrica 2a/2 | 3365 | 2053 | 5310 | 4685 | 6852 | 6499 | 7511 | 7033 | 7389 |

# *Doctors' self-insurance fund would help rural health care*

This morning, the Senate Judiciary Committee will take a look at a bill that would create a self-insurance fund for physicians delivering babies.

At first glance, it looks like a bill to help doctors. But it's not. It's a bill to help two seemingly dissimilar groups — pregnant women and small town hospitals.

Currently there are only about 55 doctors delivering babies in rural Montana towns. That sounds bad enough, but it's getting worse. Within two years only the seven largest cities in the state will offer obstetrical care.

That spells trouble for pregnant women in rural areas and for the small hospitals that won't be providing services to them. Those hospitals' already crunched budgets will be further strapped.

The problem House Bill 699 addresses is "broader than people realize," according to Gerald Neely, special counsel on liability for the Montana Medical Association and author of the bill.

When family practioners stop delivering babies because of high liability insurance rates, hospitals in small communities stand to lose "a ton of money," Neely said. "Obstetrics is just the tip of the iceberg."

The proposed bill has been well thought out. It limits risks as much as possible. Only doctors who are good risks can participate. They must have $100,000 in regular insurance before they can be considered for the additional self-insurance pool. The bill would provide immediate insurance premium decreases that would, in turn, lure doctors into staying in small towns or locating there.

The bill would be funded by a $7.3 million loan from the Board of Investments. That money is safe, according to Neely. "Chances are, not a dime of it will be expended on claims," he said. It will be held in reserve and invested.

A provision in the bill requires repayment of the loan when the self-insurance pool reaches a certain level of money, collected from physicians, hospitals and patients.

In fact, the loan may not be repaid. "It's more in the nature of an investment than a loan," Neely said. Participating doctors would fund one pool with annual premiums that will cover all claims from $100,000 to $1 million. Hospitals, doctors and obstetric patients would also contribute to an arbitration pool. Hospitals and participating doctors would pay $5 per delivery. Patients, if able, would pay $25 on their first visit to the doctor for obstetrical care.

The author of the bill admits it isn't perfect. But this state is out of alternatives. Doctors can move — and will — if insurance rates continue to rise. Pregnant women and small towns will pay the price.

We think it's a good investment in the health of Montana's babies and the viability of rural medical care.

Proctor

SENATE JUDICIARY
EXHIBIT NO. 5
DATE 4-5-89
BILL NO. HB 699

March 5, 1989
Submitted by Vicki Proctor, Dillon, MT
In testimony for House Bill 699

Hello. I am Vicki Proctor and I am from Beaverhead County.

I have had 7 pregnancies. I have 3 children. My obstetricl history has been a twisted fate which has carried my husband and myself through the extreme emotions of sorrow to the spellbinding ecstasy of joy.

Five years ago our son Jed Christian was born. He was born with a herniated diaphragm which is a condition that is incompatible with life. He struggled through and fought fiercely for his short life here with us. Though his condition was extremely rare, 1 in ten million births, it represented a situation that no medical intervention could save his life. We chose to accept the risk and the responsibility of this child when we conceived him. That is a risk that every expecting family should weigh when they enter this contract with life.

We will now quantum leap to 1987. In Mid 1987 I was referred by my local physician to Missoula when I was diagnosed pregnant. Our physician hoped to optimize our chances for a good outcome and placed our primary care there. We prayed, and dare we hope that this baby would be in our arms. Would we again have to experience the sorrow of the "empty arm" yearnings? We travelled weekly to Missoula. The miles, the expense, the stress. Was it all worth it? In December 1987 I went into pre term labor. I was 26 weeks along, my baby weighed only 1 1/2 lbs. If she was born she would have a minimal chance of survival. Realizing that I could not safely make the trip to Missoula for care, my local physician treated me aggressively in the ICU unit x 7 days with tocolytics. He successfully abated the labor. We were discharged onto strict bed rest for the next 3 months. Two days after her due date, Molly Blythe was born. All 8 lbs 3 ozs. of ecstasy.

I wonder. What if medical care was not there for Molly? She wouldn't be here. My life's twisted fate would have seen me loose her too. Our son died because his condition was medically untreatable. Molly may have died with a condition that was medically treatable, but withheld, because the lack of malpractice coverage. We again were willing to accept the risks and responsibilities for the babies we had, the babies we lost. Shouldn't the legislature be willing to accept the risks and the responsibility of preserving rural obstetrical health care? I appeal to you to support House Bill 699 as a mother, parent, and citizen of Montana who is concerned that no one else should ever have to experience the sorrow we have.

Respectfully submitted,
Vicki Proctor
683-5440

Bramlett

SENATE JUDICIARY
EXHIBIT NO. 6, P. 1
DATE 4-5-89
BILL NO. HB 699

THIS CHILD WOULD NOT HAVE SURVIVED WITHOUT THE EMERGENCY CARE WE RECIEVED AT HIS BIRTH.

Brandon Bramlette "The future of Montana"

This effects YOU!

The following is a quick story of how our youngest son survived what could of been a real tragedy.

On October 4th, 1987 I went into pre-term labor. My husband rushed me to Barrett Hospital where our physician Dr. Ken Hunt, met us. With medication the labor was stopped for a short time, but then continued. At this time we were life flighted to Missoula leaving behind three children. Because the pregnancy was only 24 weeks along and our baby, if born at this time had only a 10% chance of survival it was neccessary.

For eight long weeks my husband traveled back and forth to Missoula on the week-ends, which became both very stressfull as well as expensive. On November 22, nearly six weeks till our due date, I was able to return to my husband and children. On Thanksgiving morning, November 26, I again went into pre-term labor only this time our little guy had actually kicked his way into being born. When those little fellows want out there is no stopping them.

We again rushed to the hospital. We knew the baby was breech and that a C-section would have to be performed. What we didn't know was that the baby had the embelical cord wrapped around his neck three times.

The staff of doctors and nurses at Barrett Hospital with their speed and expertise brought both baby and I through wonderfully. Had my husband and I had to search out another hospital, even one as close as Butte, there is little chance that Brandon would be with us today.

House Bill 699 does not just apply to those having babies. This Bill effects YOU too. Many OB doctors in rural areas are family practitioners, they treat the young as well as the old. This means everyone is effected. For those doctors that can no longer afford to pay this horrendous amount for mal-practice Ins. it will mean moving to another area that will help them pay for it. This means we - you and I lose the quality of medical care we have all come to depend on.

It is time to take a stand and assure the same quality of Doctor care for your children and grand children that we, you and I, have been so lucky to receive.

I urge you to support House Bill 699.

SENATE JUDICIARY
EXHIBIT NO. 6 pg2
DATE 4-5-89
BILL NO. HB699

FACT: House Bill 699 effects you-your children and your childrens children.

FACT: These unborn children are the future of Montana.

FACT: Without proper OB care close ot home, more deaths and birth defects are sure to occure.

FACT: Every pre-term baby born at 31 weeks or before is considered a $100,000 baby of which the state pays much of.

FACT: How many of you are Grandparents? It will be a sad day when your Grandchildren have to move away to have their children.

FACT: House Bill 699 will work! PASS IT ON!!

OH BY THE WAY...

This is

Dawn Bramlette

Four weeks ago you approved of her and her fellow fiddler's as being "The Future of Montana" with a standing elevation for the Dillon Junior Fiddlers.

Dawn too was a pre-mey baby and without our local medical care could very well have never been able to perform with this very special group. We just celebrated her "8" Bithday April 3.

Again I urge you to support House Bill 699. Thankyou.

Sincerely
Susie Bramlette

Allen Chronister

SENATE JUDICIARY
EXHIBIT NO. 7 10
DATE 4-5-89
BILL NO. HB 699

Written Testimony of the State Bar of Montana on HB 699

The State Bar has taken no position supporting or opposing HB 699. The Bar does actively support the concept of improving the availability of obstetrical care. The Bar has been actively involved in the efforts in the House to improve this Bill because of its potential importance to doctors, mothers, families and communities were it to be enacted. Basically, if this bill is to be enacted, it should be the best it can be. It is not now in that condition. The following amendments are suggested for the Committee's consideration:

1. On page 14, Subsection 7(2)(b), line 20, strike the word "the" before "claim" and insert "each such". On line 22 strike the word "the" before "claim" and insert "each such".

COMMENT: This subsection requires asessments of $500 or $1000 from physicians who have certain types of adverse claims experiences. These assessments go to the secondary pool. The intent is to require the assesment for each adverse claims experience, but the language in the bill could be construed to require only a one-time assessment with all future adverse claims being "free."

2. Subsection 7(2)(a)(ii), page 14, line 14, strike the semicolon and insert a period. Then on page 14, line 15, insert before "for" the words "There is also levied". Then on page 15, line 6, insert before "after" the words "There is also levied".

COMMENT: The purpose of this is to clear up an internal inconsistency. Subsection 7(2), beginning on page 13 purports to list the funding sources for the primary pool, including subsections (a), (b), and (c). Then on page 17, subsection 7(4) states that the funds from subsections (b)

and (c) go to the secondary pool. The funds cannot go two places.

Alternatively, if fund sources (b) and (c) are intended to go to the primary pool, then strike on page 17, line 6 aafollowing "through" through "(c)," on line 7.

3. On page 19, line 14, delete "temporary line of credit" and insert "loan".

COMMENT: The funding device is no longer called a temporary line of credit.

4. On page 19, beginning on line 17, delete subsection (2) in its entirety,

COMMENT: This subsection was perhaps needed when the primary funding for the bill came from a tap on certain insurance companies. Since the funding is now essentially public, this is not needed. Further, it is confusing as to what are included as "capital contributions."

5. On page 37, line 11, after "Montana" insert "and approved by the department and the administrator,".

COMMENT: This subsection requires the State Bar to write a pamplet for general distribution that describes the operation of the Act. This amendment requires that the Department of Health and the Administrator of the Fund approve the pamplet before it is distributed.

6. On page 38, line 15, after "claim.", insert "An executed copy of the agreement to arbitrate must be provided to the administrator."

COMMENT: This is a simple notification change.

7. On page 39, line 4, following "claim" insert "except that all hearings shall be governed by the contested case and judicial review provisions of the Administrative Procedure Act." Then on page 39, line 11, insert a period after "27-6-606" and strike the remaining language through line 18.

COMMENT: This is intended to clear up some very confusing language concerning procedure that will be applicable to secondary pool claim hearings. It is doubtful that anyone can take the current bill and accurately describe the procedure applicable to one of these hearings.

The current language draws from the arbitration statutes and the medical-legal panel statutes and excepts others, but does so very confusingly. There are provisions of the medical-legal panel act--such as secrecy and prohibition of a record-- and provisions relating to arbitration--such as very restricted judicial review--that should not apply. Further, commitments were made in the House proceedings that these would not apply.

The suggested amendments are intended to simply made the Administrative Procedure Act apply.

8. On page 39, line 5, following "and" insert "an" and strike "a professional". Then on line 6 strike beginning with the period through "and" on line 7. Then on line 7 insert "who" before "is". Then on line 8 strike "chairman" and insert "chairperson".

COMMENT: This is intended to remove confusion and controversy that might arise over who is or is not a "professional" arbitrator. Further, prior sections of the bill that tied benefit levels to Workers Compensation benefits

have been largely deleted, so that expertise in that area is not important.

Currently the bill contains no mechanism for choosing the arbitrator member of the panel. The lawyer and doctor members are chosen by the director of the Medical-Legal Panel from lists submitted by the MMA and the Bar. See 27-6-401 and 402. There is nothing similar for choosing the third panel member, and a policy decision needs to be made. The lawyer and doctor could be required to agree on a third member after their appointment, for example.

9. There is no requirement that the secondary pool be operated on an actuariarly sound basis. This is largely, no doubt, due to the fact that if it were actuariarly unsound little could be done about it. It has no income source that it can control to meet an actuarial contingency. The only thing it can do, if it runs short, is to pro-rate benefits. On page 42, line 25, and on page 43, line 20, nonetheless, are references to actuarial soundness of the secondary pool. This are believed to be the act's only such references and are likely to cause hair-pulling and headaches for the person saddled with administering the secondary pool. They should probably be deleted.

10. It is doubtful that there is a mechanism in the act that will allow for any surplus to accumulate to repay any loan for start up costs, regardless of the source of the loan. This is due to the fact that the only place a surplus can come from is the primary pool, and that the primary pool must be operated on an actuarially sound basis. See Section 4(1), defining actuarial soundness.

The only controllable variable in the fund level of the primary pool is the annual premium surcharge against

member physicians. This level is set based upon annual actuarial study. Nowhere is there any requirement that actuarial soundness consider the loan repayment, and only considerations of actuarial soundness can affect the level of annual premiums collected from insured doctors. Further, only after the fund is actuarily sound and has accumulated another $1,000,000 will it start repaying any loan. There is a substantial danger that this may not happen.

The Committee should consider inserting loan repayment as an actuarial consideration in Section 8.

11. Section 31, "Applicability", is very confusing and might be stricken. It basically states that this act applies to any action as long as one of the defendants is a participating physician. What does that mean? Consider a not-atypical malpractice claim against an ob, an anestheologist, a surgeon and a pediatrician where only the ob is a participating physician. What does it mean to say that this act applies to the case? Does it mean that the primary pool is liable for all damages over $100,000?

This section is believed to be a fossil remnant of earlier drafts of the bill that contained such things a limitations on damages and attorney fees. Those are now gone, and this section should be gone too.

Davidow 5

GERALD J. NEELY
ATTORNEY AT LAW
P.O. BOX 21137
BILLINGS, MONTANA 59104

SENATE JUDICIARY
EXHIBIT NO. 8, p 1
DATE 4-5-89
BILL NO. HB 699

May 19, 1988

G. Brian Zins, Director
Montana Medical Association
2021-11th Ave.
Helena, MT 59601

Re: Doctors Company Alternative

Dear Brian:

A recent development with the Governor's Obstetrical Advisory Committee is a cause for extreme concern on the part of the Montana Medical Association. It is important that the matter be dealt with before the first week in June.

Based on statements by Leonard Kaufman to the Committee that the Doctors Company has a "quick fix" solution to the obstetrical crisis, tentative arrangements have been made for Dr. Sabella to be invited to speak before the Governor's Committee on, I believe, June 8, 1988 (or perhaps adjusted to a later time) to explain a Doctors Company "proposal".

Over time, there has been a number of hints to the proposal involving a "subsidy" from the Doctors Company, with it not being made clear what is going to be proposed and how it fits vis-a-vis the MMA proposal.

These comments have created an atmosphere of confusion at the Committee, with questions about the Doctors Company proposal being unanswered. I have been approached by some of the Committee members to explain what is happening, but have been non-committal at this point.

The cause for grave concern is this. Because the Governor and the legislature have indicated that no special session will be undertaken, any such "quick fix" would be presented at the next legislature instead of and as an alternative to the Montana Medical Association proposal. In other words, the Doctors Company proposal of necessity will be offered as and viewed as an outright rejection of the MMA proposal.

SENATE JUDICIARY
EXHIBIT NO. 8 pg 2
DATE 4-5-89
BILL NO. HB 699

The proposal as I understand it is not by any fashion a "quick fix" and it is troubling to see it described that way. It is merely another legislative proposal that would not be implemented any faster or slower than the MMA proposal; it ultimately would be of the same degree of complexity as the MMA proposal.

This poses a number of problems. First of all, at the recent meeting of the Doctors' Company, a very rough verbal indication of what the Doctors' Company had in mind was presented, with a suggestion that the various carriers and representatives from Wyoming, Hawaii, Montana, and Nevada work on a Task Force to further develop the idea and other ideas.

My understanding was that the Doctors Company was making an initial suggestion of how, with a Special Session -- hence the term "quick fix" -- a short-term publicly-funded or guaranteed approach could be utilized, to be replaced at a later general session of the legislature with different legislation. The proposal was to study the matter to flush out the details.

If the verbal idea is now presented as a concrete and formalized solution of the Doctors' Company, it totally voids the need for any such a Task Force. In fact, the MMA's participation in a Task Force whose goal is the elimination of the MMA proposal from the next legislative session would be very foolish, in the absence of something concrete from the carriers that is definitive regarding the quality (or lack of it) of the MMA proposal.

The Doctors' Company proposal as I understand it is this: The obstetrical component of all medical malpractice insurance in Montana would be placed in a pool, i.e. all claims as to all amounts involving obstetrical claims would be paid from the pool. The pool would be funded (or guaranteed???) by the State of Montana from general fund revenues and premiums would be reduced by the amount of the obstetrical component. The pool would be managed by the Doctors Company for a fee, via a contract with the State of Montana.

In other words, the proposal seems to be a variation on the MMA proposal and the Insurance Commissioner proposal.

Rather than private funding, the pool would be publicly funded. Rather than the pool beginning at low limits up to high limits, the pool would cover 100% of all obstetrical claims, as would the Insurance Commissioner proposal on a more limited basis. The pool would just cover obstetrical claims, unlike the recommended change in the MMA proposal to cover all claims against FPs and OBGYNS if those practitioners deliver babies.

Claims against the Doctors' Company pool would be handled in the tort system, like with the MMA proposal. Most importantly, the pool would not involve any degree of tort reform nor any of the other components of the MMA proposal. It is a public funded or public guaranteed pool without any fundamental change in the legal system.

SENATE JUDICIARY
EXHIBIT NO. 8 pg 3
DATE 4-5-89
BILL NO. HB 699

The consequence of this is that the Trial Lawyers Association, Montana Bar Association and any other group opposed to any form of tort reform will jump quickly to embrace the Doctors' Company alternative, because it will be a clear way to avoid any alteration in the tort system and will not likely be able to get thru the legislature.

This will especially be the case if one or more of the physicians on the Governor's Committee move towards acceptance of the Doctors' Company proposal or suggest that the Committee's discussion and debate be one of how to slightly vary or modify the Doctors' Company proposal. That possibility is apparent.

The net result could well be a rejection of the MMA proposal, the embrace of the Doctors Company proposal, and then that proposal being later rejected by the legislature because there is no possible way that the legislature would provided 100% funding for the problem, given the economic and monetary problems in Montana.

Worse, the major physician-owned carrier is about to be placed in a position of direct confrontation with the MMA (or vice versa). It would be ironic if tort reform in Montana is dealt a final death blow by a company owned by physicians.

At minimum, Dr. Sabella will be directly and strenuously questioned regarding the MMA proposal. Although some generalized verbal comments about the MMA proposal have been made, the MMA has not been provided with any written analysis from the Doctors Company as to how the MMA proposal could be improved, if they even take the position that it has any degree of merit. It seems as though the MMA ought to be entitled to some definitive response from the Doctors Company: the MMA proposal was presented to them in December. The first definitive response to the MMA proposal ought not to be in a public forum.

It is very important that direct discussion be had with Dr. Sabella and other key officials of the Doctors Company regarding the position of the Doctors Company, and a determination made as to what the position of the MMA will be at the next meeting of the Governor's Obsetrical Committee vis-a-vis a presentation of an alternative to the MMA proposal.

Sincerely,

Gerald J. Neely
Special Counsel
Montana Medical Assocation

cc: Dr. Richard Nelson
Dr. Van Kirke Nelson
Leonard Kaufman
Dr. Joseph Sabella
Charles O'Brien

Sherwood 6

SENATE JUDICIARY
EXHIBIT NO. 9
DATE 4-5-89
BILL NO. HB 699

Testimony of Michael Sherwood, MTLA
Re: House Bill 699
Opposing

I would like to begin by saying that malpractice rate increases in this state have not been the result of huge jury awards. Between 1978 and 1987 twenty-three medical malpractice cases went to trial in state district courts. Fourteen of those resulted in defense verdicts. The remaining nine resulted in verdicts tallying less than $700,000.

Only two verdicts involve obstetric settings. The first involved the death of a baby in Kalispell. The doctor's conduct was so outrageous that his license was revoked. The award was $50,000. The second involved a teenage girl in Butte, a rape victim. An abortion was performed and in the course of doing so the physician negligently sterilized the girl. She and her father recovered a total of $7,500 at trial. In short, Montana juries have been very stingy when it comes to recovery against doctors.

While the Montana Trial Lawyer's Association is not opposed to the concept found in this bill, we do oppose this particular piece of legislation for two reasons:

1. The risk of an unfunded liability; and
2. The exemption of this fund from the requirement that it engage in good faith settlement practices.

I anticipate that Karl Englund will discuss the "good faith" settlement exemption. I would like to address the unfunded liability issue. First, I would like to draw two parallels between this proposed fund and the current worker's compensation scheme:

(a) Actuarially sound rate setting.

Section 39-71-2304 MCA requires that reserves be maintained to meet both anticipated and unexpected claims.

Section 7 of this bill requires that annual surcharges be assessed to make the fund actuarily sound.

(b) A fund administered by a state agency.

Section 39-71-301 MCA provides for administration of the fund by a state agency.

Section 5 of this bill establishes a fund to be administered by the Department of Health and Environmental Sciences.

In 1987 the Workers' Compensation Fund found itself approximately $150 million into an unfunded liability. The solution reached by the legislature was not termination of the fund, was not retroactive assessment of premiums. The solution was the wholesale reduction of benefits to the injured worker.

If this legislation results in an actuarily unsound insurance fund, this legislature will be asked to reduce benefits to pregnant mothers and their babies. This request will be made for two reasons:

1. To protect the financial interests of the state in having these funds repaid and justify the interest expense that thas been incurred by the state to date. I have set this interest expense out on an attachment to my testimony.

2. To save the doctors from the consequences of having their insurance fund fail, thereby leaving them with no "tail" coverage.

In order to minimize the risks involved, I suggest the amendments which accompany this testimony.

SENATE JUDICIARY
EXHIBIT NO. 9 pg 3
DATE 4-5-89
BILL NO. HB 699

Proposed Amendments to HB 699
Submitted by Michael Sherwood, MTLA

Page 1, line 5:

Strike: "ASSURED.

PAGE 2, line 20; Page 3, Line 11; page 9, line 16; and page 11, line 3:

Strike: "Assured"

These amendments are offered because the patient is not "assured" of being compensated under this legislative scheme. Pursuant to Section 8, an injured woman or her baby could wait up to three years for compensation awarded by a court or negotiated in settlement from the primary fund. Pursuant to Section 18 an injured woman or her baby could be subjected to dilatory settlement tactics with no recourse. Pursuant to Section 22 (11), if the secondary pool is short of funds, the woman and her baby would only receive a pro rata share of the damages owed them. And, if this fund should become insolvent there is no ability to seek relief from the insurance guaranty fund.

Page 14, Line 5:

Insert after "SOUND": ", PROVIDE FOR REPAYMENT OF THE ORIGINAL FUNDS USED TO CAPITALIZE THE FUND IN A TIMELY MANNER AND PAY REINSURANCE PREMIUMS."

This amendment is proposed because, without it, the actuary need never take into account the repayment of the initial capital in assessing the annual surcharge. Repayment, pursuant to clause 10, would never occur. The reinsurance language is proposed merely to clarify the duty to reinsure pursuant to Section 11.

Page 19, line 13:

Strike: " WITHDRAWN UNDER THE TEMPORARY LINE OF CREDIT"

EXHIBIT NO. 4 094
DATE 4-5-89
BILL NO. HB699

This amendment is proposed because it no longer makes sense under the current funding mechanism.

Page 13, Line 17:

Strike: (i)

Page 14, lines 8 through 14:

Strike entire text.

Page 25, line 8:

Strike: "(i) if acting as an individual physician,"

Page 25, lines 14 through 19:

Strike entire text.

The purpose of these amendments is to eliminate physicians who are not delivering babies from the fund. The inclusion of those physicians would only serve to further jeopardize the actuarial soundness of this fund due to initial undercapitalization.

Page 14, Line 20 and Line 22:

Strike: "one-time"

The purpose of this amendment is to clarify that assessments will be made for each claim with such a result.

Page 20, line 3:

Insert after "reinsurance": "for claims beyond those anticipated in dertimining the actuarial soundness of the pool"

Black's Law Dictionary defines "reinsurance" as : "A contract by which an insurer procures a third person to insure him against loss or liability by reason of original insurance." The purpose of this amendment is to make it clear that the fund does not need to reinsure for all claims, but only for those exceeding its expected losses. This amendment will also serve to guaranty the solvency of the primary pool.

SENATE JUDICIARY
EXHIBIT NO. 9 pg 5
DATE 4-5-89
BILL NO. HB699

Page 29, line 15:

Strike: "of any kind"

Insert after "damages": "assessed against a physician"

The purpose of this amendment is to place pregnant women, their babies, and all the other patients of the phsycians qualifying under this program on the same footing as any other person injured by the malpractice of a physician by allowing a claim for bad faith settlement practices against the fund. This should serve to avoid dilatory tactics and the excessive expenditure of unneeded defense costs, as well.

SENATE JUDICIARY
EXHIBIT NO. 9 PG 6
DATE 4-5-89
BILL NO. HB699

Fiscal analysis of funding HB 699 by 6.4 Million Dollar Bond at no interest with annual surcharge language. This assumes an 8 per cent rate of return on current state investments, a 2.75 percent premium tax on premiums now paid, an annual assesment of approximately $6,000 for Family Practicioners and $12,000 for Obstetricians, and a 14 percent increase per year based upon a 14 percent increase in medical costs per year to injured victims.

COSTS

| YEAR | CASH | LOST INTEREST | LOST PREMIUM TAX INCOME |
|---|---|---|---|
| 1989 | 6,400,000 | 0 | |
| 1990 | 0 | 512,000. | 21,615 |
| 1991 | 0 | 552,960 | 24,641 |
| 1992 | 0 | 597,196 | 28,090 |
| 1993 | 0 | 644,972 | 32,023 |
| 1994 | 0 | 696,570 | 36,506 |
| 1995 | 0 | 752,295 | 41,617 |
| 1996 | 0 | 812,479 | 47,444 |
| 1997 | 0 | 877,477 | 54,086 |
| 1998 | 0 | 947,675 | 61,658 |
| | 6,400,000 | 5,797,121 | 286,022 |

This means the state would lose approximately 12,480,000 dollars in the next ten years.

## ESTIMATED NOSE COVERAGE FOR PACF- PRESENT RATES

### MATURE RATE -- 1M/3M

INCLUDES PHYSICIANS WHO ARE ASSOCIATED WITH OB'S AND FAMILY PRACTICE OB'S: 202

| THE DOCTORS' COMPANY | PHYSICIAN COUNT | TOTAL COUNT | APPROXIMATE COST | TOTAL COST |
|---|---|---|---|---|
| OBSTETRICS-GYNECOLOGY | 36 | | $ 3,084,984 | |
| FAMILY PRACTICE/OBSTETRICS | 27 | | 1,237,545 | |
| EMERGENCY MEDICINE | 3 | | 98,950 | |
| FAMILY PRACTICE?ASST/SURG. | 6 | | 98,928 | |
| FAMILY PRACTICE/MAJOR SURG. | 2 | | 65,966 | |
| INTERNAL MEDICINE | 6 | | 79,186 | |
| GENERAL SURGERY | @ | | 82,094 | |
| PEDIATRICS | 1 | | 16,488 | |
| GYNECOLOGY | 1 | | 41,047 | |
| GASTROENTEROLOGY | 1 | | 13,108 | |
| CERTIFIED NURSE MIDWIFE | 2 | | 84,341 | |
| CERTIFIED NURSE PRACTICIONER | 1 | | 7,351 | |
| | 88 | 88 | $ 4,910,078 | $ 4,910,078 |
| UTAH MEDICAL INSURANCE | | | | |
| OBSTETRICS-GYNECOLOGY | 5 | | 379,190 | |
| FAMILY PRACTICE/OBSTETRICS | 27 | | 980,991 | |
| * ASSOCIATES ESTIMATED/UMIA | 10 | | 140,000 | |
| | 42 | 130 | $ 1,500,181 | $ 6,410,259 |
| INSUR. CORP. OF AMERICA | | | | |
| OBSTETRICS-GYNECOLOGY | 5 | | 200,374 | |
| FAMILY PRACTICE/OBSTETRICS | 13 | | 372,125 | |
| * ASSOCIATES ESTIMATED/ICA | 12 | | 133,000 | |
| | 30 | 160 | $ 705,499 | $ 7,115,758 |
| ST. PAUL FIRE & MARINE | | | | |
| FAMILY PRACTICE/OBSTETRICS | 28 | | $ 672,000 | |
| * ASSOCIATES ESTIMATED/SPFM | 14 | | 140,000 | |
| | 42 | | $ 812,000 | |
| | | TOTAL = 202 | | $ 7,927,958 |

THIS ESTIMATE DOES NOT INCLUDE MMA'S 14% INFLATIONARY ANNUAL INCREASE.

IF THE FUND GOES BELLY UP AND THE PHYSICIANS HAVE TO BUY TAIL TO CONTINUE CARRIER COVERAGE, THE DOCTORS' COMPANY IS 1.8%, UMIA SAYS THEY INDIVIDUALLY FIGURE THE COST, ST. PAUL AND ICA ARE APPROXIMATELY 3.00%

EXAMPLE: THE DOCTORS' COMPANY TAIL COST WOULD BE: $ 8,838,140.

SENATE JUDICIARY
EXHIBIT NO. 9
DATE 4-5-89
BILL NO. HB699

MONTANA DEFENSE
TRIAL LAWYERS, INC.
36 SOUTH LAST CHANCE GULCH, SUITE A ☐ HELENA, MONTANA 59601 ☐ 406/443-1160

SENATE JUDICIARY
EXHIBIT NO. 9 098
DATE 4-5-89
BILL NO. HB 699

April 5, 1989

Senator Bruce Crippen
and Members of the Senate Judiciary Committee
State of Montana
Capitol Station
Helena, MT 59620

RE: House Bill 699 - Patient Assured Compensation Act

Dear Chairman Crippen and Members of the Committee:

The Montana Defense Trial Lawyers, Inc. (MDTL) acknowledges the considerable time and effort expended in drafting the "Patient Assured Compensation Act" but reluctantly concludes that our organization cannot support HB 699. As you know, members of our organization defend doctors who have been sued for malpractice.

Members of our committee who studied this issue are unable to appear before you because of a conflict in schedules. We apologize.

MDTL recognizes that rural communities face increased difficulties in operating primary health care facilities and in providing medical services, including obstetrical services, to their residents. One of those problems is the cost of physicians' professional liability insurance coverage related to the rendering of obstetrical services.

The concerns MDTL has regarding the Patient Assured Compensation Act include:

1. The proposed legislation is complex. It has numerous definitions, guidelines, limitations and administrative and judicial procedures which may, in the long run, increase the cost of resolving medical malpractice claims.

2. The "tort reform" provisions of previous bills have been removed. They were represented to be critical factors in reducing malpractice costs. Since they have been eliminated, we question how and to what extent this bill would enhance the availability of obstetrical services in Montana rural communities.

3. MDTL is aware of a number of substantial out-of-court settlements in obstetrical cases involving birth-related injuries. MDTL doubts that provisions contained in the Patient Assured Compensation Act would have affected the negotiations in those settlements, nor would it have altered the amount of the settlements.

4. MDTL concurs in the majority of the recommendations of the Governor's "Obstetrical Services Availability Advisory Council" as transmitted to the Honorable Ted Schwinden on November 2, 1988.

5. Recent developments in Montana law relating to medical malpractice are not addressed in the bill. We think they should be included.

For example, prior to 1985, rural family doctors were generally held to a standard of care based upon the standard possessed by physicians in "similar localities under similar circumstances." This was known as the "locality rule." The Montana Supreme Court abolished the rule. Family doctors are now generally held to the same standard of care as physicians practicing in larger communities. MDTL suggests the legislature consider re-establishing a locality rule so that rural physicians are judged by the "skill and learning possessed by other physicians and surgeons in good standing practicing in similar localities under similar circumstances."

Secondly, prior to 1985, juries were instructed that a doctor's conduct must be the "proximate cause" of an injury before he could be held liable. The Montana Supreme Court changed this rule. It held that where there was more than one factor at play in causing an injury, the jury should be instructed on a standard of "legal cause." Now, a jury has only to find that the physician's conduct was a "substantial factor" in causing the injury. MDTL suggests the legislature consider a return to the "proximate cause" standard in determining a physician's liability where there may be a number of factors to explain a birth-related injury, such as inadequate prenatal care by the mother, underlying disease or abnormality of the mother, and other genetic and congenital factors.

6. MDTL does not oppose a plan which would offer voluntary mediation or arbitration as an alternative to the traditional tort system for resolving medical negligence claims. MDTL does not oppose a plan which would offer a no-fault approach as an alternative to obstetrical patients but sees significant difficulties and hurdles in funding such a plan--particularly as an alternative to traditional tort resolution of such claims.

We again apologize for not being able to appear before your committee to discuss this important issue.

Sincerely yours,

MONTANA DEFENSE TRIAL LAWYERS, INC.

Robert F. James
President

**AMENDMENTS TO HOUSE BILL 699 (3rd READING, BLUE COPY)**
**PROPOSED BY THE AMERICAN INSURANCE ASSOCIATION**

1. Page 3, line 9.
Strike: ";"
Insert: ". To assure that the patient assured compensation system becomes operational, and to further assure that it does not enjoy an unfair competitive advantage over insurers transacting insurance in Montana, neither the system nor any medical liability insurer transacting insurance in Montana may be subject to the provisions of [Title 33, Chapter 16, also known as the "Regional Ratemaking Act" enacted as House Bill 247].

2. Page 17, line 19.
Following: "sound."
Insert: "Until the primary pool of funds is operational, the provisions of [Title 33, Chapter 16, known as the "Regional Ratemaking Act" enacted as House Bill 247] may not apply to medical liability insurance.

3. Page 18.
Following: line 11
Insert: "(3) Once the primary pool of funds is certified as actuarially sound under this section, the provisions of [Title 33, Chapter 16, known as the "Regional Ratemaking Act" enacted as House Bill 247] do not apply to the primary pool of funds or to any insurer insuring any participating physician in the patient assured compensation fund as required by [Section 15 of this act] or to any insurer transacting medical liability insurance in Montana.

4. Page 26.
Following: line 3
Insert: "Any insurance carrier making a filing with the administrator as permitted by this subsection is exempt from the provisions of [Title 33, Chapter 16, known as the "Regional Ratemaking Act" enacted as House Bill 247].

5. Page 29, line 1.
Strike: Section 17 in its entirety.
Insert: "NEW SECTION. Section 17. Fund to be excess carrier. The primary pool of funds is considered to be an excess carrier for all purposes under [this act].

6. Page 29.
Following: line 12
Strike: Section 18 in its entirety.

SENATE JUDICIARY
EXHIBIT NO. 10 099
DATE 4-5-89
BILL NO. HB 699

**AMENDMENTS TO HOUSE BILL 699 (3rd READING, BLUE COPY)**
**PROPOSED BY THE AMERICAN INSURANCE ASSOCIATION**

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Pg 3-7 repetition of these two pages

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5. Page 29, line 1.
Strike: Section 17 in its entirety.
Insert: "NEW SECTION. Section 17. Fund to be excess carrier. The primary pool of funds is considered to be an excess carrier for all purposes under [this act].

6. Page 29.
Following: line 12
Strike: Section 18 in its entirety.

Exhibit W.

EXHIBIT NO. 11, p. 1
DATE 4-5-89
BILL NO. HB699

MONTANA DEFENSE TRIAL LAWYERS, INC.
36 SOUTH LAST CHANCE GULCH, SUITE A ☐ HELENA, MONTANA 59601 ☐ 406/443-1160

April 5, 1989

Senator Bruce Crippen
and Members of the Senate Judiciary Committee
State of Montana
Capitol Station
Helena, MT 59620

RE: House Bill 699 - Patient Assured Compensation Act

Dear Chairman Crippen and Members of the Committee:

The Montana Defense Trial Lawyers, Inc. (MDTL) acknowledges the considerable time and effort expended in drafting the "Patient Assured Compensation Act" but reluctantly concludes that our organization cannot support HB 699. As you know, members of our organization defend doctors who have been sued for malpractice.

Members of our committee who studied this issue are unable to appear before you because of a conflict in schedules. We apologize.

MDTL recognizes that rural communities face increased difficulties in operating primary health care facilities and in providing medical services, including obstetrical services, to their residents. One of those problems is the cost of physicians' professional liability insurance coverage related to the rendering of obstetrical services.

The concerns MDTL has regarding the Patient Assured Compensation Act include:

1. The proposed legislation is complex. It has numerous definitions, guidelines, limitations and administrative and judicial procedures which may, in the long run, increase the cost of resolving medical malpractice claims.

2. The "tort reform" provisions of previous bills have been removed. They were represented to be critical factors in reducing malpractice costs. Since they have been eliminated, we question how and to what extent this bill would enhance the availability of obstetrical services in Montana rural communities.

3. MDTL is aware of a number of substantial out-of-court settlements in obstetrical cases involving birth-related injuries. MDTL doubts that provisions contained in the Patient Assured Compensation Act would have affected the negotiations in those settlements, nor would it have altered the amount of the settlements.

4. MDTL concurs in the majority of the recommendations of the Governor's "Obstetrical Services Availability Advisory Council" as transmitted to the Honorable Ted Schwinden on November 2, 1988.

5. Recent developments in Montana law relating to medical malpractice are not addressed in the bill. We think they should be included.

For example, prior to 1985, rural family doctors were generally held to a standard of care based upon the standard possessed by physicians in "similar localities under similar circumstances." This was known as the "locality rule." The Montana Supreme Court abolished the rule. Family doctors are now generally held to the same standard of care as physicians practicing in larger communities. MDTL suggests the legislature consider re-establishing a locality rule so that rural physicians are judged by the "skill and learning possessed by other physicians and surgeons in good standing practicing in similar localities under similar circumstances."

Secondly, prior to 1985, juries were instructed that a doctor's conduct must be the "proximate cause" of an injury before he could be held liable. The Montana Supreme Court changed this rule. It held that where there was more than one factor at play in causing an injury, the jury should be instructed on a standard of "legal cause." Now, a jury has only to find that the physician's conduct was a "substantial factor" in causing the injury. MDTL suggests the legislature consider a return to the "proximate cause" standard in determining a physician's liability where there may be a number of factors to explain a birth-related injury, such as inadequate prenatal care by the mother, underlying disease or abnormality of the mother, and other genetic and congenital factors.

6. MDTL does not oppose a plan which would offer voluntary mediation or arbitration as an alternative to the traditional tort system for resolving medical negligence claims. MDTL does not oppose a plan which would offer a no-fault approach as an alternative to obstetrical patients but sees significant difficulties and hurdles in funding such a plan--particularly as an alternative to traditional tort resolution of such claims.

We again apologize for not being able to appear before your committee to discuss this important issue.

Sincerely yours,

MONTANA DEFENSE TRIAL LAWYERS, INC.

Robert F. James
President

Penner Ex

SENATE JUDICIARY
EXHIBIT NO. 12 p. 1
DATE 4-5-89
BILL NO. HB 699

MR CHAIRMAN, MEMBERS OF THE COMMITTEE. FOR THE RECORD MY NAME IS JIM PENNER. I AM THE CHIEF INVESTMENT OFFICER FOR THE MONTANA BOARD OF INVESTMENTS.

I APPEAR BEFORE YOU TODAY NOT TO OPPOSE THE INTENT OF HOUSE BILL 699 BUT TO OPPOSE THE PROPOSED METHOD OF FUNDING, SPECIFICALLY, THE TEMPORARY LINE OF CREDIT FROM THE BOARD OF INVESTMENTS.

THE BOARD OF INVESTMENTS BOARD AT ITS REGULARLY SCHEDULED MEETING LAST FRIDAY REQUESTED THAT I APPEAR BEFORE YOU AND CONVEY THE BOARD'S CONCERN ABOUT THE APPARENT INCONSISTENCY BETWEEN THE "PRUDENT EXPERT PRINCIPLE" WHICH GOVERNS THE BOARDS ACTIVITIES AND THE FUNDING OF A BELOW MARKET RATE UNCOLLATERALIZED LOAN. THE BOARD OF INVESTMENTS, AS AN ENTITY, DOES NOT HAVE MONEY BUT HAS UNDER MANAGEMENT A NUMBER OF FUNDS, OR ACCOUNTS IF YOU WILL, WHICH HAVE MONEY AVAILABLE FOR INVESTMENT. FIDUCIARY RESPONSIBILITIES PREVENT THE FUNDING OF THIS TEMPORARY LINE OF CREDIT FROM THE PENSION FUNDS. THE TREASURER'S FUND IS NOT AVAILABLE AS THAT WOULD BE DEEMED AN UNAUTHORIZED APPROPRIATION UNLESS APPROVED BY THE LEGISLATURE. THAT LEAVES ONLY THE TRUST FUNDS AS A POTENTIAL SOURCE OF FUNDING.

FROM THE BOARD'S PERSPECTIVE, THE PERMANENT COAL TRUST FUND AND THE IN-STATE FUND ARE THE ONLY TRUST FUNDS POTENTIALLY ELIGIBLE FOR THIS TYPE OF LOAN. THE PERMANENT COAL TRUST FUND HOLDINGS ARE PREDOMINANTLY INVESTMENT GRADE CORPORATE BONDS YIELDING ON AVERAGE 10.5% BUT DOES INCLUDE SELECTIVE MONTANA LOANS LIKE THE GREAT FALLS GAS COMPANY PRIVATE PLACEMENT AND THE LIVINGSTON REBUILD CENTER LOAN. BOTH OF THOSE LOANS ARE FULLY COLLATERALIZED. IT ALSO HAS ABOUT 10 SBA GUARANTEED LOANS FROM AROUND MONTANA. ALL OF THESE INVESTMENTS HAVE A WELL DEFINED REPAYMENT SCHEDULE WHICH IS LACKING IN THE PROPOSED LEGISLATION.

THE IN-STATE FUND IS A $60 MILLION FUND BUT HAS A STATUTORY MAXIMUM PER LOAN AMOUNTING TO 10% OF THE ANNUAL FLOW OF CASH INTO THE FUND OR ABOUT $1 MILLION PER LOAN. USE OF THIS FUND IF THE STATUTE WERE OVERRIDDEN WOULD MEAN 12% OF THE FUND WOULD BE INVESTED IN ONE FUND WHICH IS, IN

SENATE JUDICIARY
EXHIBIT NO. 11 092
DATE 4-5-89
BILL NO. HB699

TE JUDICIARY
IT NO. 11 093
4-5-89
NO. HB699

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disease or abnormality of the mother, and
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before your

MY OPINION, INADEQUATE DIVERSIFICATION AS REQUIRED UNDER THE PRUDENT EXPERT PRINCIPLE. I ALSO BELIEVE THAT 17-6-310 PROHIBITS DIRECT LOANS AND WOULD ALSO HAVE TO BE AMENDED.

THANK YOU.

Williams

SENATE JUDICIARY
EXHIBIT NO. 13
DATE 4-5-89
BILL NO. HB 699

AMRPE

Association of Montana Retired Public Employees

Post Office Box 4721
Helena, Montana
59604

*A non-profit corporation of P.E.R.S. Retirees for P.E.R.S. Retirees*

TESTIMONY HB 699
DICK WILLIAMS, PRESIDENT

The Association of Montana Retired Public Employees is a non-profit organization of approximately 4,000 members representing retired municipal, county and state employees. Our members are participants in the Public Employee Retirement System. As with most retirees, our members have worked most of their lives in order to save enough money to enjoy retirement, or at least to get by. The PERS trust fund is our savings account.

Until last week, our Association was unconcerned about HB 699. We want to clearly state that the objectives of the bill are most laudable. Providing a mechanism to insure adequate medical services for the delivery and care of babies is certainly a fine objective. However, the source of funds used to create the insurance pool is any funds controlled by the Board of Investments. Potentially, the pool could be funded by the savings account of PERS retirees. The bill calls for over $7 million to be "loaned" to the pool at 4 percent interest, which is substantially below the current rate of return. There appears to be no security for the loan.

Not only is the Association concerned about HB 699 but also the precedent it would set for raiding our savings account. What laudable program will next look to the trust funds. While not opposed to the objectives of HB 699, I seriously doubt that many of the Association's members will be able to use its services. We would therefore urge you to change its funding mechanism.

Paul Fire and Marine Insurance Company
sh: gton Street, St. Paul, Minnesota 55102
ne (612) 221 7911

SENATE JUDICIARY
EXHIBIT NO. 14, p.1, 164
DATE 4-5-89
BILL NO. HB 699

The St Paul
Property & Liability Insurance

INSURANCE DEPARTMENT
STATE OF MONTANA
REVIEWED AND FILED
FOR INFORMATIONAL PURPOSES
Date JUN 13 1986
ANDREA (ANEY) BENNETT
STATE AUDITOR AND
COMMISSIONER OF INSURANCE

May 28, 1986

Honorable Andrea Bennett
Commissioner of Insurance
Mitchell Building
Helena, Montana 59601

Medical Professional Liability
Physicians and Surgeons Professional Liability - Claims Made
Rate and Increased Limit Factor
Revisions

257371
FEE PAID BY CHECK #
345366@10.
OUR RECEPTION #

Dear Madam:

This letter and the enclosed material are being submitted as an independent filing on behalf of the St. Paul Fire and Marine Insurance Company.

By this filing we propose an overall rate increase of 21.9% for our Physicians and Surgeons Professional Liability - Claims Made Program. This increase consists of a 14.3% for $100,000 basic limits and a 6.6% for Increased Limit Factors. Complete explanation and support can be found in the enclosed Rate Filing Memorandum and Exhibits.

We would like to point out, however, that since most of our policies are written at $1,000,000/$3,000,000 limits, we have included rate pages reflecting these limits. This is a convenience for our staff.

Your acknowledgment of this filing to be effective July 1, 1986, by stamping and returning the extra copy of this letter will be appreciated.

Yours truly,

ST. PAUL FIRE AND MARINE INSURANCE COMPANY

Holly DuBord

Holly DuBord
Assistant State Filings Director
Insurance Law Department
(612) 221-7595

HD:nls

Encl.

St. Paul Fire and Marine Insurance Company
St. Paul Mercury Insurance Company
Physicians and Surgeons Professional Liability

Section II
Introductory Comments

This section provides information essential to a complete understanding of the filing. It describes how the data from occurrence and claims-made policies are combined in order to make rates for a claims-made policy form.

A. General Comments

1. The data contained in the filing is the experience of The St. Paul, both occurrence and claims-made.

2. The filing contains references to combined states experience. Exhibit 1 provides a list of the states whose experience makes up the combined states data.

3. Premium and loss experience from claims-made policies appear in Exhibits 2 and 3. Ten report years of frequency-severity experience (occurrence and claims-made) appear in Appendix C. This data is provided for informational purposes.

4. The data, both exposures and losses, in the exhibits is arranged to recognize both the reported period and the accident period. This allows experience from occurrence contracts to be used as well as experience from our claims-made contracts. The accident period is recognized in the exhibits through the lag. The lag is the report period minus the accident period.

   All experience is on a semi-annual basis. This permits more accurate pricing. It also permits use of partial years of experience.

B. Losses

1. The loss data in the filing includes allocated loss adjustment expenses as well as loss. All losses, excluding loss adjustment expense, are limited to $100,000 per claim.

2. The loss data contains both paid amounts and current case reserves (for claims reported, but not yet settled). These amounts are shown separately for this state in Exhibit 6 and for the combined states in Exhibit 7.

   These case reserves are modified in Exhibits 9 (this state) and 10 (combined states) for expected case reserve development. The case reserve development factors appear in Exhibits 8A and 8B. They are based upon the historic pattern of reserve settlements for The St. Paul. The development factors used in this state are derived from its own experience combined with that of other states having similar development. Appendix A of the filing provides more detail on these case development factors.

St. Paul Fire and Marine Insurance Company
St. Paul Mercury Insurance Company
Physicians and Surgeons Professional Liability

SENATE JUDICIARY
EXHIBIT NO. 14 pg 3
DATE 4-5-89
BILL NO. HB699

Exhibit 1

States Included in Combined States

| | | |
|---|---|---|
| Alabama | Maine | Oregon |
| Arkansas | Minnesota | South Dakota |
| Colorado | Mississippi | Tennessee |
| Idaho | Missouri | Texas |
| Indiana | Montana | Vermont |
| Iowa | Nebraska | Washington |
| Kansas | North Carolina | Wisconsin |
| Kentucky | North Dakota | Wyoming |
| Louisiana | Ohio | |

Neely. Y

SENATE JUDICIARY
EXHIBIT NO. 15
DATE 4-5-89
BILL NO. HB 699

# ANNUAL STATEMENT

OF

# THE DOCTORS' COMPANY, AN INTERINSURANCE EXCHANGE

OF

# SANTA MONICA

IN THE

# STATE OF CALIFORNIA

TO THE

## Insurance Department

OF THE

## STATE OF

---

**FOR THE YEAR ENDED**
**DECEMBER 31, 1985**

1985

**FIRE AND CASUALTY**

**1985**

(Name)

*Designate the type of health care providers reported on this page

## SUPPLEMENT "A" TO SCHEDULE T
## EXHIBIT OF MEDICAL MALPRACTICE PREMIUMS WRITTEN
## ALLOCATED BY STATES AND TERRITORIES

| 1 States, Etc. | 2 Number of Exposures | 3 Direct Premiums Written* | 4 Direct Premiums Earned* | Direct Losses Paid 5 Amount | Direct Losses Paid 6 No. of Claims | 7 Direct Losses Incurred | Direct Losses Unpaid 8 Amount Reported | Direct Losses Unpaid 9 No. of Claims | 10 Direct Losses Incurred But Not Reported |
|---|---|---|---|---|---|---|---|---|---|
| 1. Alabama AL | | | | | | | | | |
| 2. Alaska AK | | | | | | | | | |
| 3. Arizona AZ | | | | | | | | | |
| 4. Arkansas AR | | | | | | | | | |
| 5. California CA | 91,887 | 71,367,267 | 70,192,325 | 22,342,814 | 1,703 | 44,726,476 | 137,745,518 | 3,887 | 3,410,000 |
| 6. Colorado CO | | | | | | | | | |
| 7. Connecticut CT | | | | | | | | | |
| 8. Delaware DE | | | | | | | | | |
| 9. Dist. Columbia DC | | | | | | | | | |
| 10. Florida FL | | | | | | | | | |
| 11. Georgia GA | | | | | | | | | |
| 12. Hawaii HI | | | | | | | | | |
| 13. Idaho ID | | | | | | | | | |
| 14. Illinois IL | | | | | | | | | |
| 15. Indiana IN | | | | | | | | | |
| 16. Iowa IA | | | | | | | | | |
| 17. Kansas KS | | | | | | | | | |
| 18. Kentucky KY | | | | | | | | | |
| 19. Louisiana LA | | | | | | | | | |
| 20. Maine ME | | | | | | | | | |
| 21. Maryland MD | | | | | | | | | |
| 22. Massachusetts MA | | | | | | | | | |
| 23. Michigan MI | | | | | | | | | |
| 24. Minnesota MN | | | | | | | | | |
| 25. Mississippi MS | | | | | | | | | |
| 26. Missouri MO | | | | | | | | | |
| 27. Montana MT | 3,765 | 2,077,410 | 1,970,398 | 250,750 | 26 | 4,475,666 | 6,461,244 | 122 | 100,788 |
| 28. Nebraska NE | | | | | | | | | |
| 29. Nevada NV | 7,700 | 4,090,760 | 4,367,572 | 1,925,206 | 103 | 3,599,049 | 10,156,500 | 189 | 237,420 |
| 30. New Hampshire NH | | | | | | | | | |
| 31. New Jersey NJ | | | | | | | | | |
| 32. New Mexico NM | | | | | | | | | |
| 33. New York NY | | | | | | | | | |
| 34. No. Carolina NC | | | | | | | | | |
| 35. No. Dakota ND | | | | | | | | | |
| 36. Ohio OH | | | | | | | | | |
| 37. Oklahoma OK | | | | | | | | | |
| 38. Oregon OR | | | | | | | | | |
| 39. Pennsylvania PA | | | | | | | | | |
| 40. Rhode Island RI | | | | | | | | | |
| 41. So. Carolina SC | | | | | | | | | |
| 42. So. Dakota SD | | | | | | | | | |
| 43. Tennessee TN | | | | | | | | | |
| 44. Texas TX | | | | | | | | | |
| 45. Utah UT | | | | | | | | | |
| 46. Vermont VT | | | | | | | | | |
| 47. Virginia VA | | | | | | | | | |
| 48. Washington WA | | | | | | | | | |
| 49. West Virginia WV | | | | | | | | | |
| 50. Wisconsin WI | | | | | | | | | |
| 51. Wyoming WY | 1,181 | 518,311 | 467,311 | 292,500 | 0 | 449,297 | 960,400 | 21 | 26,000 |
| 52. American Samoa AS | | | | | | | | | |
| 53. Guam GU | | | | | | | | | |
| 54. Puerto Rico PR | | | | | | | | | |
| 55. U.S. Virgin Is. VI | | | | | | | | | |
| 56. Canada CN | | | | | | | | | |
| 57. Other alien(Itemize)** OT | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| 58. Totals | 103,733 | 78,053,756 | 76,995,606 | 24,829,270 | 1,840 | 53,250,288 | 155,323,662 | 3,619 | 3,775,000 |

*Gross Premiums, Include Policy and Membership Fees, Less Return Premiums on Policies Not Taken. Include in this Exhibit the Medical Malpractice Portion of any Policy for which the Premiums for Medical Malpractice are Separately Stated. Include all one-half of the Premium is for Medical Malpractice Coverage.

All Separate Supplement "A" Must be used for each designated type of Including Surgeons and Osteopaths;(2) Hospitals;(3) Other Health Care Professionals, Including Dentists;(4) Other Health Care Facilities; for to January 1, 1976.

If a claim count is included in Losses Paid, it must not be included

**All U.S. business must be allocated by state regardless of licensee

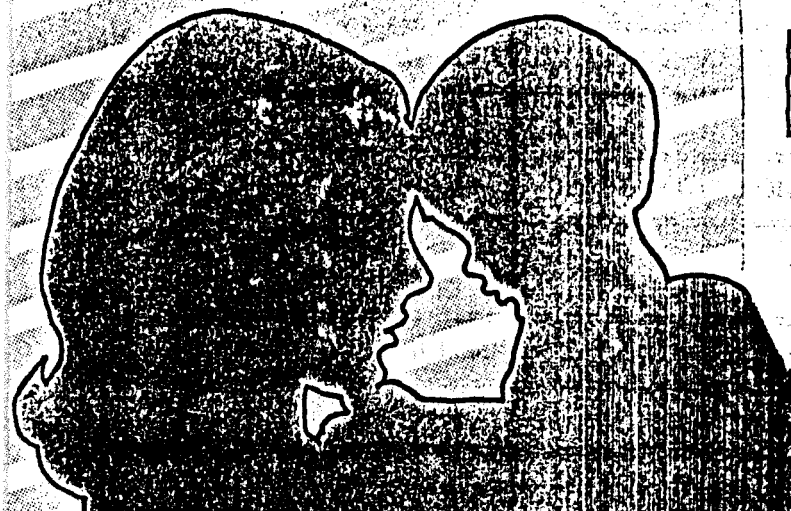
Revised 1984.

NOTE: See additional instructions on reverse side.

EXH, #10

SENATE JUDICIARY
EXHIBIT NO. 16
DATE 4-5-89
BILL NO. HB 699

BACKGROUND ON HB 699: Montana Patient Assured Compensation Act



# THE LOSS OF OBSTETRICAL SERVICES IN MONTANA

prepared by the
Montana Medical Association

SENATE JUDICIARY
EXHIBIT NO. 17 p.1
DATE 4-15-89
BILL NO. HB699

**SUMMARY OF HB 699**
Third Reading Copy (BLUE)

For the Committee on Judiciary

Prepared by Valencia Lane
April 3, 1989

HB 699 is designed to relieve the crisis in availability of obstetrical care in rural areas of Montana. The bill's goal is to make it more economically feasible for doctors providing obstetrical care to remain in rural Montana areas. One method of doing this is to lower insurance premiums for obstetrical medical malpractice insurance.

The bill creates two mechanisms to accomplish its goals: the primary pool of funds (to provide excess insurance) and the secondary pool of funds (to provide a no-fault system of compensation) to those persons injured by obstetrical malpractice.

The bill creates a source of insurance to provide medical malpractice coverage for doctors in excess of established limits. This is done through the primary pool of funds [see attached flow chart].

The bill also creates a no-fault system of compensation similar to the Workers' Compensation Fund. This is done through the secondary pool of funds [see attached flow chart].

**SUMMARY OF SECTIONS**

P.2 * **Section 1. Short title.**

P.2 * **Section 2. Purpose and goals.**

P.4 * **Section 3. Legislative findings.** Specifically finds a severe statewide public health and economic problem regarding availability of obstetrical services in Montana. (P. 4)

P.6 * **Section 4. Definitions.**

P.11 * **Section 5. Fund created -- attachment to department -- deposit and investment.** Creates "patient assured compensation fund". Attached to Department of Health and Environmental Sciences for administrative purposes only.

Department give rulemaking authority. Funds in trust -- segregated funds (primary and secondary) -- to be invested in fiduciary manner.

P.11 * **Section 6. Reimbursement to departments.** Primary pool of funds to reimburse Dept. of Health and Insurance Dept. for expenses incurred in administration of act.

P.11 * **Section 7. Capitalization and maintenance of primary pool of funds and secondary pool of funds -- surcharge.**

(1) Loan of $7.25 million from Bd. of Investments to primary pool of funds and loan of $100,000 from Bd. of Investments to secondary pool of funds -- not appropriations and must be repaid with 4% interest. (P. 13)

(2)(a)(i) Annual surcharge against participating doctor (apparently set by rule -- doesn't specifically say) for excess insurance coverage above $100,000/$300,000 [up to $1 million/$3 million limits] (P. 14)

(2)(a)(ii) Annual surcharge against profession service corporation. To be determined by actuary [question -- why wasn't doctor's surcharge to be determined by actuary?]. [question -- can't understand lines 12 & 13, P. 14].

(2)(b) One-time penalty tax against doctors who have had successful malpractice claims against them = $500 or $1,000. [question -- one-time means one time only in a lifetime or one per year? this is still under (2) = "annual surcharge"]. (P.14) **[GOES TO SECONDARY POOL OF FUNDS].**

(2)(c) $5/per delivery from each participating doctor and $5/per delivery from each hospital. (P. 15) **[GOES TO SECONDARY POOL OF FUNDS].**

(3) Collections.

(4) **SECONDARY FUND TO BE MAINTAINED THROUGH SURCHARGES ON DOCTORS AND HOSPITALS (subsections (2)(b) and (2)(c)), ANY DISTRIBUTIONS FROM SURPLUS (SECTION 10), $25 DESIGNATED PREMIUM EQUIVALENT (SECTION 22), AND ANY OTHER REVENUES.** (P.17)

P.17 * **Section 8. Actuarial soundness of primary pool of funds.** Primary pool of funds must be kept actuarially sound. If not actuarially sound, claims to be prorated and paid at end of 1-year following 2-year period, with interest.

P.18 * **Section 9. Staff.** Fund can be used to hire staff.

P.18 * **Section 10. Return of savings.** Surplus (over the amount needed to keep fund actuarially sound plus $1 million) in Primary Pool of Funds to be distributed one-half to Bd. of Investments to repay loan (P. 19, line 14 needs clarification -- refers to "line of credit", also in Title, line 22 -- left over from earlier drafts) and one-half to Secondary Pool of Funds. Note: bill does not say what happens to the half going to Board of Investments when loan paid off. Note: State Bar of Montana questions whether Primary Pool will ever generate sufficient surplus to pay off loan or fund Secondary Pool.

P.20 * **Section 11. Reinsurance authority.** The fund to obtain reinsurance.

P.20 * **Section 12. Claims for payment.** Final claims to be paid within 30 days, except as provided for Secondary Pool no-fault system (Section 22) and in Section 8(2) [payments prorated when fund does not have sufficient funds].

P.20 * **Section 13. Claims against fund -- procedure.**

P.21 * **Section 14. Payment from primary pool of funds after exhaustion of insurance coverage -- excess claims -- procedure.** If claimant demands an amount in excess of his primary insurance carrier's limits, he is to present claim to administrator of the fund (Director of Montana Medical Legal Panel) in form of a short, plain written statement of the nature of the claim and the additional amount for which the claimant will settle.

P.24 * **Section 15. Qualifications for physicians.** To participate, doctor must be licensed in Mt., pay all surcharges, at time of qualification irrevocably agree in writing to be bound by the results of any arbitration, have medical liability insurance in amount of required limits, and

establish proof of qualifying coverage for lower limits and proof of specialty. Required limits of primary insurance coverage = $100,000 per occurrence and $300,000 in the annual aggregate for all claims made during the policy period (P. 26, line 1). Note: Subsection (c)(i) and (c)(ii) unclear.

P.26 * **Section 16. Failure of physician to qualify for change of coverage-- limits of liability of fund -- rights and duties of physician.** Nonqualified doctor subject to all liability without regard to this bill (P. 26, line 16 -- this is left over from original draft of bill when bill contained limits on liability). Primary Pool of Funds not liable for amounts covered by doctor's primary insurance coverage. Secondary pool of funds liable only up to the amounts contained in that fund. Primary Pool not liable until doctor's primary insurance has paid up. **Maximum liability of primary pool of funds is $1 million per occurrence and $3 million in the annual aggregate as to each qualified doctor.** (P. 27, lines 10 through 12). Rights and duties of doctor are same under Primary Pool of Funds as under his individual coverage, including exceptions, exclusions, and endorsements. Doctor ceases to be qualified for coverage under Primary Pool when his individual coverage terminates.

P.29 * **Section 17. Adequate defense of fund -- notification as to reserves.**

P.29 * **Section 18. Primary pool of funds not liable for punitive damages.** Does not relieve doctor of liability for punitive damages.

P.29 * **Section 19. Appointment and recommendations of obstetrical advisory council.** Dept. of Health to appoint council, subject Governor's approval. Seven member, 4-year terms. Council to make recommendation regarding: prenatal and postnatal care, risk prevention, designated compensable events for which compensation should be made, economic and noneconomic schedules, and changes to this law.

P.30 * **Section 20. Disciplinary action against physicians.** Board of Medical Examiner to investigate doctors who have 3

or more adverse malpractice claims $10,000 in 5-year period. Bd. to publish summary of action taken under this section annually after 1995.

P.33 * **Section 21. Contractual right to extended reporting endorsements -- prior acts coverage.** Doctor can buy coverage from Primary Pool of Funds that extends beyond period in which he is qualified under Primary Pool of Funds. Doctor can get prior acts coverage if same is covered under private policy for lower limits; subject to limitations on P. 34, line 25 through P. 35, line 20.

P.35 * **Section 22. Compensation for injuries from medical intervention without regard to fault.** SECONDARY POOL OF FUNDS -- NO-FAULT SYSTEM.

(1) Compensation without regard to liability of doctor.

(2) Patient becomes eligible for coverage under Secondary Pool of Funds at time of initial medical treatment by participating doctor. Patient becomes liable for $25 designated premium equivalent.

(3) Doctor must inform patient at time of initial treatment of provisions of this section and give them pamphlet describing bill (Pamphlet to be written by State Bar of Montana and paid for by Primary Pool of Funds.) Designate premium to be added to first bill sent to patient by doctor.

(4)(a) Doctor to submit $25 to Dept. of Health.

(4)(b) If claim arises, patient may provide doctor with an agreement to arbitrate. P.38, line 13-15 states that the doctor and patient shall execute claim. Note: the implication is that doctor must agree to arbitrate if patient submits agreement. Note: no indication what is to be done with agreement once is signed, i.e., patient not required to submit to Medical Legal Panel. **Up to this point, patient can stop no-fault process and proceed through law suit.**

(5) through (7) If claim pursued, claim to be filed with Medical Legal Panel naming Primary Pool of Funds as a party. Arbitration panel to be composed of attorney, physician, and

a "professional" arbitrator. At this point, patient is bound to no-fault system. Filing claim constitutes waiver of trial and award is sole and exclusive remedy. (P. 40, lines 2 and 3).

(8) If no claim filed under (7), filing claim with federal court or with Medical Legal Panel constitutes waiver of arbitration agreement.

(9) Recovery limited to required benefits.

(10) Required benefits = past expenses (P. 41, lines 21 and 22); future expenses (P. 41, lines 23-25); sum equal to one and one-half times state's average weekly wage for period of disability (P. 42, lines 1 and 2); and reasonable attorney fees (P. 42, lines 3-5). Does not include reimbursements received under state or federal law.

(11) Payments to be made monthly to extent sufficient funds available. (P. 42. lines 18-25). If funds not sufficient, payments to be prorated.

(12) Administrative costs of Secondary Pool of Funds to be paid from Secondary Pool of Funds. Administrative costs have priority over benefits. A loan can be obtained from Primary Pool of Funds for administrative costs and attorney fees (only).

(13) Arbitration agreement form by Dept. of Health to have written notice on its face of substance of subsections (7) through (10).

(14) Statute of limitations is that in 27-2-205 (3 years or 3 years from date of discovery but no more than 5 years).

P.44 * **Section 23. Tax exemption.** Fund exempt from taxes.

P.44 * **Section 24. Review.** Director of Medical Legal Panel (administrator of fund) to report to each regular session of Legislature on effectiveness of bill.

P.44 * **Section 25. Amend 27-6-105.** Authorize Medical Legal Panel to review arbitration agreements.

P.44 * **Section 26. Amend 27-6-602.** Authorize Med. Leg. Panel to decide awards under this bill.

P.47 * **Section 27. Amend 33-23-311.** Require Insurance

Commissioner to report certain information to appropriate licensing authorities.

P.49 * **Section 28. Amend 17-6-202.** Give Bd. of Investments discretionary authority to make loan to Fund.

P.50 * **Section 29. Extension of authority.**

P.50 * **Section 30. Severability.** Bill is severable. Administrator can petition district court to terminate the bill if parts held invalid and funds' soundness impaired.

P.53 * **Section 31. Applicability.** Note: difficult to understand meaning of this section. Probably is a leftover from original draft when bill contained limits on liability.

P.54 * **Section 32. Effective date.** Effective on passage and approval.

SENATE JUDICIARY
EXHIBIT NO. 1M, p. 8
DATE 4-5-89
BILL NO. HB 699

§7 P11

## Primary Pool of Funds

- # 7.25 million – loan from Bd. of Investments (discretionary) P.50
- # ? annual premiums paid by doctors (set by Rule)
- # ? investment income

LOAN P. 43 → for administrative costs + attorney fees (only)

§7 P11-17

## Secondary Pool of Funds

- # 100,000 – loan fr... Bd. of Invest... (discretionary)
- # 25 premium... by wom... who goes ... participating doctor
- # 5/per delivery paid by hospital
- # 5/ per deliver... paid by participatin... doctor
- # ? ½ of any surplus distr... by Primary F...

½ of any surplus to secondary pool of funds

½ of any surplus to Bd. of Investments to repay loan

Primary pool of funds acts as excess insurer for participating doctors i.e. pays claims, judgments, settlements, in excess of Doctor's primary insurance limits of #100,000/per occurrence and #300,000/annual aggregate P. 26

§22 P.35

## No-fault system

① claimant executes arbitration agreem...

② Takes arb. agreement to Doctor (implicati... is he has to sign) claimant can stop her...

③ files claim with Medical/Legal Panel

-opts into No-fault
P.38 subsect. (5)
P.39 subsect. (7)

**RECOVERY:** P. 41 + 42

- medicals incurred to d...
- future medicals
- 1½ times state's average weekly wage for disability
- reasonable attorney fees

SENATE JUDICIARY
EXHIBIT NO. 18
DATE 4-5-89
BILL NO. Confirmation Hearing

# Montana State Senate

*The Big Sky Country*

WORKERS COMPENSATION COURT
CONFIRMATION HEARING

*******

APRIL 5, 1989

Old Supreme Court Chamber

10:00 A.M.

Room 325

MONTANA STATE CAPITOL

*******

By The

SENATE JUDICIARY COMMITTEE
Bruce C. Crippen, Chairman

*******

REAPPOINTMENT

OF

WORKERS COMPENSATION JUDGE .....TIMOTHY REARDON

(This sheet to be used by those testifying on a bill.) HB 699

NAME: JOSEPH D. SABELLA, M.D. DATE: 4/5/89

ADDRESS: THE DOCTORS' COMPANY
401 WILSHIRE BLVD
SANTA MONICA, CA 90401

PHONE: (213) 451-3011 Ext 360

REPRESENTING WHOM? THE DOCTORS COMPANY

APPEARING ON WHICH PROPOSAL: HB 699

DO YOU: SUPPORT? _____ AMEND? ✓ OPPOSE? ✓

COMMENT:

PLEASE LEAVE ANY PREPARED STATEMENTS WITH THE COMMITTEE SECRETARY.

HB699

(This sheet to be used by those testifying on a bill.)

NAME: R. M. L. Johnson, MD DATE: 4/5/89

ADDRESS: 834 So. Montana Butte

PHONE: 782-4792

REPRESENTING WHOM? Myself & Mont. Med. Assn

APPEARING ON WHICH PROPOSAL: HB 699

DO YOU: SUPPORT? X AMENDED? _____ OPPOSE? _____

COMMENT: I am an Obstetrician Gynecologist. At present I pay $47000.00 per year just for Medical Liability Ins. I paid $2500.00 in 1972. This is an 18.8 fold increase. I cannot get any more from my patients to cover these rises. I'm at the mercy of the Insurance Co. that wants to increase its reserves and the trial lawyers who get unrealistic jury liability in every thing I do. Nearly half of my pages is the practice of OB in Montana have been driven out by the rises. I don't want to be next

VISITORS' REGISTER

Judiciary COMMITTEE

BILL NO. HB 699 DATE 4-5-89

SPONSOR

| NAME (please print) | RESIDENCE | SUPPORT | OPPOSE |
|---|---|---|---|
| LEONARD KAUFMAN | Billings | | X |
| George J. Neely | Billings | X | |
| Robert McLaughlin | Butte | X | |
| BRIAN TIPS | HELENA | X | |
| Barbara E Cooper | Clancy | X | |
| Jim Landoe | Helena | ✓ | |
| John Deland | " | X | |
| Richard E Wilcox | Helena | | X |
| Dennis Hemmer | Helena | | amend X |
| Steve Brown | Helena Bd of Inv. | | X amend. |
| Bonnie Tippy | Alliance for Am Insurers | | X |
| Joe Roberts | MT Defense Trial Lawyers | | amend ✓ |
| James R Brown | Helena Bd of Investment | | Amend |
| Roger McGlenn | ITAM | | X |
| J. MICHAEL SADAJ MD | BUTTE | ✓ | |
| Michael Sherwood | MTLA | | ✓ |
| Jacqueline Terrell | Am. Ins. Assoc. | | X |
| Rod Ashabraner | State Farm Insurance | | X |
| Allen Chronister | State Bar of Montana | | X |
| GENE PHILLIPS | NAII | | X |

IF YOU CARE TO WRITE COMMENTS, ASK SECRETARY FOR WITNESS STATEMENT FORM.

PLEASE LEAVE PREPARED STATEMENT WITH SECRETARY.